



# WVCHIP PRIOR AUTHORIZATION FORM

## FAX 1-844-633-8431 DENTAL/ORTHODONTIC

Today's Date \_\_\_\_\_

REGISTRATION ON C3 IS REQUIRED TO SUBMIT PRIOR AUTHORIZATION REQUESTS WHETHER BY FAX OR ELECTRONICALLY. DETERMINATIONS ARE AVAILABLE ON [HTTPS://PROVIDERPORTAL.KEPRO.COM](https://providerportal.kepro.com)

C3 Requesting/Submitting Organization \_\_\_\_\_ Please list exactly as registered on C3

Address, City, State, Zip \_\_\_\_\_

C3 Requesting/Submitting Organization NPI \_\_\_\_\_ Please list exactly as registered on C3

Person Submitting Request \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

### Referring/Ordering Provider

(Per policy the Referring/Ordering Provider must be actively enrolled with WVCHIP)

<b>Name</b> Do not write "See Above"	<b>NPI Number</b>	
<b>Contact Information</b>	<b>Phone</b>	<b>Fax:</b>

### Place of Service/Service Provider

(Per policy the Place of Service/Service Provider must be actively enrolled with WVCHIP)

<b>Name</b> Do not write "See Above"	<b>NPI Number</b>	
<b>Address, City, State, Zip</b>		

Member WVCHIP Number \_\_\_\_\_ DOB \_\_\_\_\_

Member First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Procedure Type:  DENTAL  ORTHODONTIC

Authorization Type:  Prior Authorization

Retrospective WVCHIP Eligibility

Retrospective Request, if applicable list the appropriate reason:

List Other Retro Reason:

Type of Admission/Procedure:  Emergency/Medically Urgent  Non-Urgent

**ICD-10: R68.89**

**\*\*\*Please note: Selection of the Orthodontic Procedure Type requires submission of only Orthodontic Service Codes. For all other Dental Services, please select the Dental Procedure Type\*\*\***

**Reason for Dental/Orthodontic Requested Procedure**

**Previous relevant dental/orthodontic history (including treatments, symptoms and recommendation)**

Number of Visits for Crown: \_\_\_\_\_

<b>Dental Service Code:</b>	<b>Dental Service Code:</b>	<b>Dental Service Code:</b>	<b>Dental Service Code:</b>
<b>Start Date:</b>	<b>Start Date:</b>	<b>Start Date:</b>	<b>Start Date:</b>
<b>Place of Service</b> <input type="checkbox"/> 11-Office <input type="checkbox"/> 12-Home <input type="checkbox"/> 13-Assisted Living Facility <input type="checkbox"/> 14-Group Home	<b>Place of Service</b> <input type="checkbox"/> 11-Office <input type="checkbox"/> 12-Home <input type="checkbox"/> 13-Assisted Living Facility <input type="checkbox"/> 14-Group Home	<b>Place of Service</b> <input type="checkbox"/> 11-Office <input type="checkbox"/> 12-Home <input type="checkbox"/> 13-Assisted Living Facility <input type="checkbox"/> 14-Group Home	<b>Place of Service</b> <input type="checkbox"/> 11-Office <input type="checkbox"/> 12-Home <input type="checkbox"/> 13-Assisted Living Facility <input type="checkbox"/> 14-Group Home
<b>Oral Cavity Region</b> <input type="checkbox"/> Whole Mouth <input type="checkbox"/> Upper/Maxillary Arch <input type="checkbox"/> Lower/Mandibular Arch	<b>Oral Cavity Region</b> <input type="checkbox"/> Whole Mouth <input type="checkbox"/> Upper/Maxillary Arch <input type="checkbox"/> Lower/Mandibular Arch	<b>Oral Cavity Region</b> <input type="checkbox"/> Whole Mouth <input type="checkbox"/> Upper/Maxillary Arch <input type="checkbox"/> Lower/Mandibular Arch	<b>Oral Cavity Region</b> <input type="checkbox"/> Whole Mouth <input type="checkbox"/> Upper/Maxillary Arch <input type="checkbox"/> Lower/Mandibular Arch
<b>Tooth Number/Quadrant</b> <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px;"></div>	<b>Tooth Number/Quadrant</b> <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px;"></div>	<b>Tooth Number/Quadrant</b> <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px;"></div>	<b>Tooth Number/Quadrant</b> <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px;"></div>
<b>Surface</b> <input type="checkbox"/> Buccal <input type="checkbox"/> Distal <input type="checkbox"/> Facial (or labial) <input type="checkbox"/> Incisal <input type="checkbox"/> Lingual <input type="checkbox"/> Mesail <input type="checkbox"/> Occlusal	<b>Surface</b> <input type="checkbox"/> Buccal <input type="checkbox"/> Distal <input type="checkbox"/> Facial (or labial) <input type="checkbox"/> Incisal <input type="checkbox"/> Lingual <input type="checkbox"/> Mesail <input type="checkbox"/> Occlusal	<b>Surface</b> <input type="checkbox"/> Buccal <input type="checkbox"/> Distal <input type="checkbox"/> Facial (or labial) <input type="checkbox"/> Incisal <input type="checkbox"/> Lingual <input type="checkbox"/> Mesail <input type="checkbox"/> Occlusal	<b>Surface</b> <input type="checkbox"/> Buccal <input type="checkbox"/> Distal <input type="checkbox"/> Facial (or labial) <input type="checkbox"/> Incisal <input type="checkbox"/> Lingual <input type="checkbox"/> Mesail <input type="checkbox"/> Occlusal
Procedure Documentation/Information	Procedure Documentation/Information	Procedure Documentation/Information	Procedure Documentation/Information

**PLEASE SUBMIT ALL RELEVANT REVIEW DOCUMENTATION TO INCLUDE BUT NOT LIMITED TO RADIOGRAPHS, FILMS, X-RAYS**

## ORTHODONTIC QUESTIONS ONLY

Post Treatment Stabilization

Yes  No

Total Fee for Requested Treatment \$ \_\_\_\_\_

Recommendations for Comprehensive Orthodontic Treatment

Orthodontic-Frequency of Visits  Weekly  Bi-Weekly  Monthly  Other

If Other, please specify

### MUST MEET ALL CRITERIA:

- Radiographs: panoramic, cephalometric and cephalometric tracing
- Dental Molds: Upper and Lower study casts trimmed to the correct occlusion
- Photos: Intra and Extra Oral
- Treatment plan to include findings, diagnosis, prognosis, length of treatment, phases of treatment and specific code requested.

### MUST MEET AT LEAST ONE OF THE FOLLOWING CRITERIA:

- Overjet in excess of 7mm
- Severe malocclusion associated with dento-facial deformity
- True Anterior open bite
- Full cusp classification from normal (Class II or Class III)
- Palatal impingement of lower incisors into the palatal tissue causing tissue trauma
- Cleft Palate, congenital or developmental disorder
- Anterior Crossbite (2 or more teeth, in cases where gingival stripping from the crossbite is demonstrated and not correctable by limited orthodontic treatment.)
- Unilateral posterior crossbite with deviation or bilateral posterior crossbite involving multiple teeth including at least one molar
- True Posterior open bite (Not involving partially erupted teeth or one or two teeth slightly out of occlusion and not correctable by habit therapy)
- Impacted teeth (excluding 3<sup>rd</sup> molars) cuspids and laterals only