Wyoming Department of Health

WYOMING MEDICAID SEVERE MALOCCLUSION
TREATMENT REQUEST FORM

CLIENT NAME	CLIENT ID	CLIENT DATE OF BIRTH	EXAM DATE	LOCATION
PROVIDER GROUP NAME	GROUP NPI	TREATING PROVIDER NAME	TREATING NPI	FEE

PART 1. TREATMENT REQUESTED

FULL TREATMENT ☐ INTERCEPTIVE TREATMENT ☐ TRANSFER CASE ☐

OF MONTHS: _____

REQUIRES MAXILLO-FACIAL SURGERY? YES ☐ NO ☐

EXPLAIN:

PART 2. DIAGNOSTIC INFORMATION

STAGE OF DENTITION: PRIMARY ☐ PERMANENT ☐ MIXED ☐

SKELETAL CLASSIFICATION

Class 1 ☐ Class 2 ☐ Class 3 ☐

TMJ YES ☐ NO ☐

POSTERIOR CROSSBITE YES ☐ NO ☐

TEETH INVOLVED: _____

MISSING TEETH (indicate related teeth)			**LOCATION**
ECTOPIC ERUPTION (EXCLUDING 3RDs):	YES ☐	NO ☐	
MISSING	YES ☐	NO ☐	
IMPACTED	YES ☐	NO ☐	
ANKYLOSED	YES ☐	NO ☐	
SUPERNUMERARY	YES ☐	NO ☐	
SEVERE TRAUMATIC DEVIATION (explain):	YES ☐	NO ☐	

PART 3. BRIEF INITIAL OPINIONS

ORAL HYGIENE: GOOD ☐ FAIR ☐ POOR ☐

RESTORATIONS COMPELTE: YES ☐ NO ☐
(if no< please explain plan)

PART 4. HLD INDEX (see instructions for scoring guidelines)

		HLD SCORE
CLEFT PALATE DEFORMITIES: *indicate with an **X***		
IMPACTED ANTERIOR TEETH: *indicate with an **X***		
DEEP IMPINGING OVERBITE: *indicate with an **X** only if tissue destruction*		
ANTERIOR CROSSBITE: *indicate with an **X** only if tissue destruction*		
SEVERE TRAUMATIC DEVIATION: *must document in Part 2- score 15 pts*		
OVERJET IN mm	x1=	
OVERBITE IN mm	x1=	
MANDIBULAR PROTRUSION IN mm	x5=	
OPENBITE IN mm	x4=	
ECTOPIC ERUPTION: count each tooth	x3=	
ANTERIOR CROWDING (score 1 pt for max and 1 pt for mand -- the max # of pts for this is 10)	x5=	
POSTERIOR UNILATERAL CROSSBITE: 4 points		
TOTAL POINTS		

Treatment Narrative (provide any additional information that will substantiate your request for treatment):

PLEASE NOTE: the HLD scoring is a guideline for your use and reference for the program consultant. You will still be required to send in photographs and supporting radiographs. The program will make the final decision regarding medical necessity and scoring criteria.

MAIL COMPLETE REQUEST ALONG WITH PA FORM TO:

WYOMING MEDICAID, ATTN: DENTAL SERVICES, PO BOX 667, CHEYENNE, WY 82003-0067

WYDENTAL@conduent.com

I certify that I am the Performing Provider and that the medical necessity information is true, accurate, and complete, to the best of my knowledge.
I certify that I performed the above noted examination on this client.

PERFORMING PROVIDER SIGNATURE	PRINT NAME	DATE