Wyoming Department of Health

CONSIDERATION FOR ORAL SURGERY
RELATED TO ORTHODONTIC APPROVAL

ORAL SURGEON NAME: _____

NPI: _____ DATE OF CONSULTATION: _____

CLIENT NAME: _____ MEDICAID ID#: _____

REFERRING DENTIST NAME: _____

CONDITION REFERRED FOR: _____

_____

WERE XRAYS AND/OR RECORDS SENT WITH THIS REFERRAL? ☐ YES ☐ NO

BASED ON YOUR EXAMINATION AND REVIEW OF THE RECORDS, PLEASE PROVIDE YOUR TREATMENT PLAN FOR THIS CLIENT RELATED TO THEIR SURGERY/ORTHODONTIC NEEDS. PROCEDURE CODES, FEES, AND TIMELINES SHOULD BE INCLUDED IN YOUR RECOMMENDATIONS.

_____

_____

_____

_____

ARE THERE ANY ALTERNATIVE RECOMMENDATIONS FOR THIS CLIENT?

_____

_____

DID THE CLIENT REPORT ANY OF THE FOLLOWING CONDITIONS:

☐ JAW PAIN
☐ JOINT PAIN
☐ FACIAL PAIN
☐ HEADACHES
☐ EAR PAIN
☐ GRIND TEETH
☐ JOINT POP
☐ LOCKED JAW
☐ LIMITED MOUTH OPENING
☐ PROBLEMS WITH MASTICATION
☐ STRESS RELATED TO THEIR APPEARANCE

_____ _____
DENTIST'S SIGNATURE DATE

RETURN THIS FORM WITH ANY SUPPORTING DOCUMENTATION TO THE ADDRESS BELOW

Wyoming Medicaid
Attn: Dental Services
PO Box 667
Cheyenne, WY 82003-0067
WYDENTAL@conduent.com