Instructions for completing the Medicaid Prior Authorization for Severe Malocclusion Program Services

Completing the Medicaid Prior Authorization Form for Medical Services ***Denotes a Required Field** **NOTE:** Is this an Add, Modify or Cancel request?		
Field Number	Title	Action
1*	**Date of Birth**	**Enter MMDDYY of Client's Date of birth**
2	Age	Enter Client's Age
3*	**Medicaid ID Number**	**Enter the client's ten-digit Medicaid ID Number**
4*	**Patient Name**	**Enter Last Name, First Name and Middle Initial exactly as it appears on the Medicaid ID card**
5*	**Pay-To Provider NPI #**	**Enter the Pay to Provider NPI Numbers**
6*	**Pay To Provider Taxonomy**	**Enter the Pay To Provider Taxonomy**
7*	**Pay To Provider Name**	**Enter the Pay To Provider Name**
8	Street Address	Enter the Pay To Provider Street Address
9	City, State, Zip Code	Enter the Pay To Provider City, State and Zip Code
10*	**Telephone – Contact Person**	**Enter phone number of the contact person for this prior authorization**
11*	**Contact Name**	**Enter the name of the person that can be contacted regarding this Prior Authorization**
12*	**Proposed Dates of service**	**Enter to the best of your ability what dates of service are you looking for. It can be one day or a date range.**
13*	**Service Description**	**Enter the service that you are requesting**
14*	**Dental Code**	**Dental Code for the service(s) being requested**
15	Modifier(s)	Modifier needed to bill the procedure on the claim – If no modifiers needed – put N/A or leave blank
16*	**Unit(s)**	**Enter number of each service requested.**
17*	**Estimated Cost**	**Enter dollar amount times the unit(s) for each service requested.**
18*	**Treating Provider NPI Number**	**Enter the Treating Provider NPI Number – Needs to be a Wyoming Medicaid Provider**
19*	**Supporting Documentation**	**Please attach all documentation to support medical necessity, including color photographs and x-rays. Additional documentation may be attached when necessary.**
20	Modifications	This is the entry of changes that are needed by the provider from the original request.
21*	**Signature**	**The form needs to be signed and dated by the entity requesting the prior authorization of services**.
22	Pending Authorization	If called in for a verbal authorization, put the name of the person giving the PA number and date**.**

NOTE: YOUR PRIOR AUTHORIZATION REQUEST FORM NEEDS TO MATCH THE LINES ON THE CLAIM THAT YOU WILL BE BILLING

Wyoming Department of Health

Prior Authorization Request

To Avoid Delays – Please fill out completely

☐ **ADD**

☐ **MODIFY**

☐ **CANCEL**

PATIENT INFORMATION

1. DOB	2. AGE	3. MEDICAID ID #
4. PATIENT NAME (Last, First, MI)		

PROVIDER INFORMATION

5. PAY-TO PROVIDER NPI #	6. TAXONOMY
7. PAY-TO PROVIDER NAME	
8. STREET ADDRESS	
9. CITY, STATE, ZIP CODE	
10. TELEPHONE	11. CONTACT NAME

SERVICE INFORMATION

12. PROPOSED DATES OF SERVICE	**12a. FROM**	**12b. TO**

13. SERVICE DESCRIPTION	14. PROC CODE	15. MODIFIER(S)	16. UNITS	17. ESTIMATED COST	18. TREATING PROVIDER NPI NUMBER

19. **PLEASE ATTACH SUPPORTING DOCUMENTATION SHOWING MEDICAL NECESSITY**

Applicable documentation must be supplied in sufficient detail to satisfy the medical necessity for the prescribed service. Additional documentation may be attached when necessary.

20. **PLEASE NOTE BELOW WHICH MODIFICATIONS ARE REQUESTED**

21. TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECSSARY TO THE HEALTH OF THE PATIENT.

SIGNATURE OF PROVIDER: **DATE:**

22. PENDING AUTHORIZATION GIVEN BY	22a. DATE	22b. PRIOR AUTHORIZATION #

AUTHORIZATION (FOR FISCAL AGENT USE ONLY)

AUTHORIZATION IS VALID FOR SERVICES	FROM DATE	TO DATE	PRIOR AUTHORIZATION #

COMMENTS / EXPLANATION

WYOMING MEDICAID Attn: DENTAL SERVICES ● PO BOX 667● CHEYENNE, WY 82003-0667

● 1-8 ● FAX: ( ) ● wydental@conduent.com

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

Wyoming Department of Health

Medicaid Client Primary Dental Insurance Attestation Form

☐ New ☐ Change

Client Information	
1. CLIENT NAME:	2. CLIENT MEDICAID ID NUMBER:
3. CLIENT DOB:	4. CLIENT SSN:

5. Other Dental Insurance Coverage: ☐ Yes ☐ No*
* If no, continue to Provider Information.

6. Orthodontic Services Covered: ☐ Yes ☐ No

Insurance Information	
7. INSURANCE COMPANY NAME:	11. GROUP NUMBER:
	12. START DATE (MM/DD/YY):
8. INSURANCE COMPANY ADDRESS:	13. END DATE (MM/DD/YY):
	14. ORTHO BENEFITS:
9. POLICY HOLDER:	
10. POLICY NUMBER:	

15. POLICY HOLDER RELATIONSHIP TO CLIENT:

☐ Self ☐ Absent Parent ☐ Other ☐ Parent
☐ Spouse ☐ Brother/Sister ☐ Uncle/Aunt ☐ Grandparent
☐ Legal Guardian

Provider Information	
16. NAME:	17. NPI:
18. COMPLETED BY:	19. DATE SUBMITTED:

Include with all SMP Prior Authorization requests

FISCAL AGENT USE ONLY

DENTAL SERVICES INPUT BY: _____ DATE: _____

TPL VERIFIED BY: _____ DATE: _____

TPL INPUT BY: _____ DATE: _____