WV MEDICAID PRIOR AUTHORIZATION FORM

Today's Date _____ **FAX 1-844-633-8431 DENTAL/ORTHODONTIC**

REGISTRATION ON C3 IS REQUIRED TO SUBMIT PRIOR AUTHORIZATION REQUESTS WHETHER BY FAX OR ELECTRONICALLY.
DETERMINATIONS ARE AVAILABLE ON 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 WV Medicaid)

Name Do not write "See Above"	**NPI Number**	
Contact Information	**Phone**	**Fax:**

Place of Service/Servicing Provider

(Per policy the Place of Service/Servicing Provider must be actively enrolled with WV Medicaid)

Name Do not write "See Above"	**NPI Number**
Address, City, State, Zip	

Member Medicaid Number _____ **DOB**_____

Member First Name _____ **Last Name** _____

Procedure Type: ☐ **DENTAL** ☐ **ORTHODONTIC (< age 21 only)**

Authorization Type:

☐**Prior Authorization**

☐**Retrospective Request, if applicable list the appropriate reason:**

☐**Denied by Member's Primary Payer** ☐**Retrospective Medicaid Eligibility**

List Other Retro Reason:

For Members under age 21, is this request an EPSDT referral? ☐**Yes** ☐**NO** ****If yes, please submit the most current EPSDT form on file****

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

ICD-9: 780(Retro Dates)/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: _____

Dental Service Code:	Dental Service Code:	Dental Service Code:	Dental Service Code:
Start Date:	**Start Date:**	**Start Date:**	**Start Date:**
Place of Service ☐11-Office ☐12-Home ☐13-Assisted Living Facility ☐14-Group Home	**Place of Service** ☐11-Office ☐12-Home ☐13-Assisted Living Facility ☐14-Group Home	**Place of Service** ☐11-Office ☐12-Home ☐13-Assisted Living Facility ☐14-Group Home	**Place of Service** ☐11-Office ☐12-Home ☐13-Assisted Living Facility ☐14-Group Home
Oral Cavity Region ☐Whole Mouth ☐Upper/Maxillary Arch ☐Lower/Mandibular Arch	**Oral Cavity Region** ☐Whole Mouth ☐Upper/Maxillary Arch ☐Lower/Mandibular Arch	**Oral Cavity Region** ☐Whole Mouth ☐Upper/Maxillary Arch ☐Lower/Mandibular Arch	**Oral Cavity Region** ☐Whole Mouth ☐Upper/Maxillary Arch ☐Lower/Mandibular Arch
Tooth Number/Quadrant	**Tooth Number/Quadrant**	**Tooth Number/Quadrant**	**Tooth Number/Quadrant**
Surface ☐Buccal ☐Distal ☐Facial (or labial) ☐Incisal ☐Lingual ☐Mesail ☐Occlusal	**Surface** ☐Buccal ☐Distal ☐Facial (or labial) ☐Incisal ☐Lingual ☐Mesail ☐Occlusal	**Surface** ☐Buccal ☐Distal ☐Facial (or labial) ☐Incisal ☐Lingual ☐Mesail ☐Occlusal	**Surface** ☐Buccal ☐Distal ☐Facial (or labial) ☐Incisal ☐Lingual ☐Mesail ☐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 palatial 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 3rd molars) cuspids and laterals only