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Distribution: Submit first copy to: Ohio Department of Job and Family Services, Prior Authorization Unit, P.O. Box 1002, Columbus, Ohio 43216-0002. Do **not send invoices with prior authorization requests.** Approved Prior Authorization is contingent upon eligibility of client at the time of service and the department's claim filing limitation. Completion of this form is required by Rules 5101:3-5 of the Ohio Administrative Code in order for provider to be eligible for reimbursement for Medicaid services requiring prior authorization.

Ohio Department of Job and Family Services REFERRAL EVALUATION CRITERIA FOR COMPREHENSIVE ORTHODONTIC TREATMENT

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Check the symptoms and signs of physical conditions that you observe in this patient. Dentofacial Abnormality Marked protruding upper jaw and teeth Underdeveloped lower jaw and teeth, receding chin Excessively spaced front teeth Upper or lower teeth protruding so much that lips cannot be brought together without strain Marked protruding lower jaw and teeth Extremely "crooked" front teeth Marked asymmetry of lower face or transverse deficiencies Clefts of lip or face Abnormalities of dental development Other (explain on other side of page)													
	issue Damage Related to Malocclusion Marked recession of the gums Loosened permanent teeth Other (explain on other side of page)												
 Mastication Related to Malocclusion Extreme grimacing or excessive motions of the oral-facial muscles during swallowing Socially unacceptable behavior during eating because of necessary compensation for anatomic facial deviations Pain in jaw joints when eating Other (explain on other side of page) 													
Res	piration and Speech Related to Male Postural abnormalities with breathing Malocclusion of jaws related to chron Lisping or other speech articulation e History of, or recommendation for spe Other (explain on other side of page)	difficulties nic mouth breathing errors in children 9 ye eech therapy	ears c	old c	or yo	ung	ger						

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Dentist Signature