Ohio Department of Job and Family Services
Appendix
5101:3-5-01

PRIOR AUTHORIZATION FOR DENTAL SERVICES

State Use Only
Prior Authorization Control Number

Type or Print Legibly.

Check appropriate box for appropriate service
☐ Dentures ☐ Partials ☐ Orthodontics ☐ Endodontics / Crowns
☐ Oral Surgery ☐ TMJ ☐ Other

ENCLOSURES ☐ Study Models ☐ X-rays ☐ Evaluation ☐ LTCF Plan of Care

Medicaid Legacy Number	Contact Person
NPI Number	Contact Person
Provider Name	
Current Street Address	
City, Street, and Zip Code	
Provider Telephone No. *(include area code)*	Date Form Completed

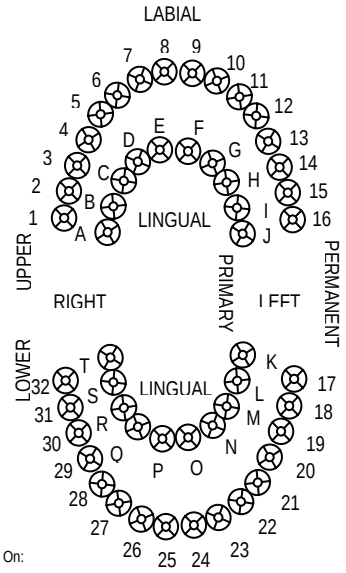
Consumer Number		Consumer Age
Case Lot Name	First Name	
Current Street Address/Facility Name and Address		
City, Street, and Zip Code	Medicare/BCMH No.	
Patient Resides: ☐ Personal Residence ☐ Long Term Care Facility ☐ Other. Specify: ____		

PROSTHODONTICS **TO THE BACK OF THIS FORM, ATTACH ENCLOSURES**

Initial Placement	Prior Placement	Date of Prior Placement	Date of Extractions	Dentist who Extracted Teeth	Prosthodontics Placement
☐ Yes ☐ No	☐ FU ☐ PU ☐ FL ☐ PL				☐ FU ☐ PU ☐ FL ☐ PL

REQUESTED SERVICES

	Quantity	Item or Procedure Code	Tooth Number	Usual and Customary Charge	Dates of Previous Service(s)
1					
2					
3					
4					Dates of Service(s)
5					
6					
Dentist's Findings			Detailed Plan of Treatment		



STATE USE ONLY – DO NOT COMPLETE BELOW

	Quantity	Item or Procedure Code	Tooth Number	Usual and Customary Charge	DETERRED	APPROVED	DENIED	Decision Based On:
1					☐	☐	☐	
2					☐	☐	☐	
3					☐	☐	☐	
4					☐	☐	☐	
5					☐	☐	☐	
6					☐	☐	☐	
Dentist's Findings			Detailed Plan of Treatment					

Reviewer

Date

Line No. **Decision – Narrative**

____ ____
____ ____
____ ____
____ ____

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

CONSUMER NAME	CONSUMER NUMBER										
PROVIDER NAME	MEDICAID LEGACY										
	NPI NUMBER										

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)

Tissue 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)

Respiration and Speech Related to Malocclusion

- ☐ Postural abnormalities with breathing difficulties
- ☐ Malocclusion of jaws related to chronic mouth breathing
- ☐ Lisping or other speech articulation errors in children 9 years old or younger
- ☐ History of, or recommendation for speech therapy
- ☐ Other (explain on other side of page)

Dentist Signature	Date