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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

CONSUMER NAME CONSUMER NUMBER													
		CONSUMER NUMBER											
PROV	IDER NAME	MEDICAID LEGACY											
		NPI NUMBER											
Den	tofacial Abnormality Marked protruding upper jaw and teeth Underdeveloped lower jaw and teeth Excessively spaced front teeth Upper or lower teeth protruding so m Marked protruding lower jaw and teeth Extremely "crooked" front teeth Marked asymmetry of lower face or to Clefts of lip or face Abnormalities of dental development Other (explain on other side of page)	eth , receding chin uch that lips cannot l th ransverse deficiencie	be br						nout	stra	in		
	Marked recession of the gums Loosened permanent teeth Other (explain on other side of page)												
Mas	tication Related to Malocclusion Extreme grimacing or excessive moti Socially unacceptable behavior durin facial deviations Pain in jaw joints when eating Other (explain on other side of page)	g eating because of				_			_	r ana	atom	ic	
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						

Date

Dentist Signature