

**ORTHOGNATHIC SURGERY  
PRIOR AUTHORIZATION FORM**



This form must be completed by a person with thorough clinical knowledge of the member's current clinical presentation and his/her clinical evaluation history. **Clinical documentation supporting the medical necessity of this request is required.** For more information, please refer to the medical policy document MC/B002 Orthognathic Surgery located at <https://www.preferredone.com/MedicalPolicy/>.

Please email this form and clinical documentation to [Intake@Preferredone.com](mailto:Intake@Preferredone.com) or fax to (763) 847-4014.

<b>Patient Name</b>		<b>PreferredOne ID #</b>		<b>DOB</b>	
<b>ICD 10 DX</b>		<b>Ordering Provider Signature</b>		<b>Procedure Code(s)</b>	
<b>Ordering Provider First &amp; Last Name</b>				<b>NPI #</b>	
<b>Clinic Name</b>				<b>NPI #</b>	
<b>Address</b>				<b>City</b>	
<b>Phone</b>		<b>Fax</b>		<b>State</b>	
				<b>Zip</b>	
<b>Servicing Provider First &amp; Last Name</b>				<b>NPI #</b>	
<b>Address</b>				<b>City</b>	
<b>Phone</b>		<b>Fax</b>		<b>State</b>	
				<b>Zip</b>	

<b>PREFERREDONE MAY AUTHORIZE COVERAGE OF ORTHOGNATHIC SURGERY WHEN THE MEMBER PRESENTS WITH ONE OF THE FOLLOWING SKELETAL DEFORMITY ABNORMALITIES IN AT LEAST ONE OF THE THREE STANDARD SPATIAL REFERENCE PLANES (Check all that apply):</b>		
<b>ANTERO-POSTERIOR DISCREPANCIES (&gt; 2 STANDARD DEVIATIONS [SD] FROM NORM)</b>		<b>Check Box</b>
Maxillary/mandibular incisor relationship	Overjet of 5 mm or more, or a value less than or equal to 0 (norm 2 mm)	
Maxillary/mandibular antero-posterior molar relationship	Discrepancy of 4 mm or more (norm 0-1 mm)	
<b>VERTICAL DISCREPANCIES</b>		<b>Check Box</b>
Presence of a vertical facial skeletal deformity which is 2 or more SDs from published norms for acceptable skeletal landmarks		
Open Bite	No vertical overlap of anterior teeth greater than 2 mm	
	Unilateral or bilateral posterior open bite greater than 2 mm	
Deep overbite with impingement or irritation of buccal or lingual soft tissues or the opposing arch		
Supraeruption of a dento-alveolar segment due to lack of opposing occlusion		
<b>TRANSVERSE DISCREPANCIES</b>		<b>Check Box</b>
Presence of a transverse skeletal discrepancy which is 2 or more SDs from published norms		
Total bilateral maxillary palatal cusp to mandibular fossa discrepancy of 4 mm or greater, or a unilateral discrepancy of 3 mm or greater, given normal axial inclination of the posterior teeth		
<b>ASYMMETRIES</b>		<b>Check Box</b>
Antero-posterior, transverse or lateral asymmetries greater than 3 mm with concomitant occlusal asymmetry		
<b>MEMBER MUST ALSO HAVE ANY ONE OF THE FOLLOWING SIGNIFICANT FUNCTIONAL IMPAIRMENTS NOT CORRECTABLE THROUGH DENTAL THERAPEUTICS AND ORTHODONTICS ALONE (Check all that apply):</b>		
<b>DYSPHAGIA (MUST HAVE ALL)</b>		<b>Check Box</b>
Symptoms related to difficulty chewing, such as choking due to incomplete mastication, or difficulty swallowing chewed solid food, or reliance on liquid food		
Symptoms documented in the medical or dental record and persisting for at least 12 months		
Other causes of swallowing or choking problems have been ruled out by history, physician exam, and appropriate diagnostic studies including but not limited to allergies, neurologic or metabolic disease, or hypothyroidism.		

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<b>Patient Name</b>
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<b>MALNUTRITION</b>	<b>Check Box</b>
Documented malnutrition, significant weight loss, or failure-to-thrive secondary to facial abnormality	
<b>SPEECH ABNORMALITIES</b>	<b>Check Box</b>
Determined by a multidisciplinary team (e.g. speech pathologist or therapist with a cleft palate or craniofacial specialist) to be due to the malocclusions and not alleviated by speech therapy or orthodontia	
<b>MASTICATORY DYSFUNCTION OR MALOCCLUSION (MUST HAVE ALL)</b>	<b>Check Box</b>
Completion of skeletal growth as evidenced by serial cephalometrics showing no change in facial bone relationships over the last three to six month period (Class II malocclusions and individuals age 18 and over do not require this documentation)	
Documentation of malocclusion with either intra-oral casts (if applicable) bilateral, lateral x-rays, cephalometric radiograph with measurements, panoramic radiographs or tomograms.	