ORTHOGNATHIC SURGERY AUTHORIZATION FORM

PreferredOne®

This form must be completed by a person with thorough clinical knowledge of the member's current clinical presentation and his/her treatment history. The entire form must be completed as clearly and specifically as possible. Omissions, generalities, and illegibility will result in the form being returned for further completion or clarification. For more information, please refer to the medical criteria document MC/B002 Orthognathic Surgery located at https://www.preferredone.com/MedicalPolicy/.

Please fax this form and other relevant documents to (763) 847-4014.

Patient Name	**Patient DOB**	**Date of Service**
Patient ID#	**Dx/ICD-10**	**Procedure Code/s**
Provider Name	**Provider Phone**	
Provider ID#	**Provider Fax**	**Provider Signature**

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):		
ANTERO-POSTERIOR DISCREPANCIES (> 2 STANDARD DEVIATIONS [SD] FROM NORM)		**Check Box**
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)	☐
VERTICAL DISCREPANCIES		**Check Box**
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		☐
TRANSVERSE DISCREPANCIES		**Check Box**
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		☐
ASYMMETRIES		**Check Box**
Antero posterior, transverse or lateral asymmetries greater than 3 mm with concomitant occlusal asymmetry		☐
MEMBER MUST ALSO HAVE ANY ONE OF THE FOLLOWING FUNCTIONAL IMPAIRMENTS NOT CORRECTABLE THROUGH DENTAL THERAPEUTICS AND ORTHODONTICS ALONE (Check all that apply):		
DYSPHAGIA (MUST HAVE ALL)		**Check Box**
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.		☐
MALNUTRITION		**Check Box**
Documented malnutrition, significant weight loss, or failure-to-thrive secondary to facial abnormality		☐
SPEECH ABNORMALITIES		**Check Box**
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		☐
MASTICATORY DYSFUNCTION OR MALOCCLUSION (MUST HAVE ALL)		**Check Box**
Completion of skeletal growth with long bone x-ray or 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.		☐