

WVCHIP PRIOR AUTHORIZATION FORM

Today's Date _____ **FAX 1-844-633-8431 DENTAL/ORTHODONTIC**
 REGISTRATION ON ATREZZO IS REQUIRED TO SUBMIT PRIOR AUTHORIZATION REQUESTS WHETHER BY FAX OR ELECTRONICALLY.
 DETERMINATIONS ARE AVAILABLE ON [HTTPS://ATREZZO.ACENTRA.COM](https://atrezzo.acentra.com)

Atrezzo Requesting/Submitting Organization _____
 Address, City, State, Zip _____

Atrezzo Requesting/Submitting Organization NPI _____ Please list exactly as registered

Person Submitting Request _____ Phone _____ Fax _____ Email _____

Referring/Ordering Provider (Per policy the Referring/Ordering Provider must be actively enrolled with WVCHIP)

Name Do not write "See Above"	NPI Number	
Contact Information	Phone	Fax:

Place of Service/Service Provider (Per policy the Place of Service/Service Provider must be actively enrolled with WVCHIP)

Name Do not write "See Above"	NPI Number	
Address, City, State, Zip		

Member WVCHIP Number _____ DOB _____

Member First Name _____ Last Name _____

Procedure Type: DENTAL ORTHODONTIC

Authorization Type: Prior Authorization
 Retrospective WVCHIP Eligibility
 Retrospective Request, if applicable list the appropriate reason:

List Other Retro Reason:

Type of Admission/Procedure: Emergency/Medically Urgent Non-Urgent

ICD-10: R68.89

*****Please note: Selection of the Orthodontic Procedure Type requires submission of only Orthodontic Service Codes. For all other Dental Services, please select the Dental Procedure Type*****

Reason for Dental/Orthodontic Requested Procedure

Previous relevant dental/orthodontic history (including treatments, symptoms and recommendation)

Dental Service Code:	Dental Service Code:	Dental Service Code:	Dental Service Code:
Start Date:	Start Date:	Start Date:	Start Date:
Place of Service <input type="checkbox"/> 11-Office <input type="checkbox"/> 12-Home <input type="checkbox"/> 13-Assisted Living Facility <input type="checkbox"/> 14-Group Home	Place of Service <input type="checkbox"/> 11-Office <input type="checkbox"/> 12-Home <input type="checkbox"/> 13-Assisted Living Facility <input type="checkbox"/> 14-Group Home	Place of Service <input type="checkbox"/> 11-Office <input type="checkbox"/> 12-Home <input type="checkbox"/> 13-Assisted Living Facility <input type="checkbox"/> 14-Group Home	Place of Service <input type="checkbox"/> 11-Office <input type="checkbox"/> 12-Home <input type="checkbox"/> 13-Assisted Living Facility <input type="checkbox"/> 14-Group Home
Oral Cavity Region <input type="checkbox"/> Whole Mouth <input type="checkbox"/> Upper/Maxillary Arch <input type="checkbox"/> Lower/Mandibular Arch	Oral Cavity Region <input type="checkbox"/> Whole Mouth <input type="checkbox"/> Upper/Maxillary Arch <input type="checkbox"/> Lower/Mandibular Arch	Oral Cavity Region <input type="checkbox"/> Whole Mouth <input type="checkbox"/> Upper/Maxillary Arch <input type="checkbox"/> Lower/Mandibular Arch	Oral Cavity Region <input type="checkbox"/> Whole Mouth <input type="checkbox"/> Upper/Maxillary Arch <input type="checkbox"/> Lower/Mandibular Arch
Tooth Number/Quadrant <input type="text"/>	Tooth Number/Quadrant <input type="text"/>	Tooth Number/Quadrant <input type="text"/>	Tooth Number/Quadrant <input type="text"/>
Surface <input type="checkbox"/> Buccal <input type="checkbox"/> Distal <input type="checkbox"/> Facial (or labial) <input type="checkbox"/> Incisal <input type="checkbox"/> Lingual <input type="checkbox"/> Mesail <input type="checkbox"/> Occlusal	Surface <input type="checkbox"/> Buccal <input type="checkbox"/> Distal <input type="checkbox"/> Facial (or labial) <input type="checkbox"/> Incisal <input type="checkbox"/> Lingual <input type="checkbox"/> Mesail <input type="checkbox"/> Occlusal	Surface <input type="checkbox"/> Buccal <input type="checkbox"/> Distal <input type="checkbox"/> Facial (or labial) <input type="checkbox"/> Incisal <input type="checkbox"/> Lingual <input type="checkbox"/> Mesail <input type="checkbox"/> Occlusal	Surface <input type="checkbox"/> Buccal <input type="checkbox"/> Distal <input type="checkbox"/> Facial (or labial) <input type="checkbox"/> Incisal <input type="checkbox"/> Lingual <input type="checkbox"/> Mesail <input type="checkbox"/> Occlusal
Procedure Documentation/Information	Procedure Documentation/Information	Procedure Documentation/Information	Procedure Documentation/Information

PLEASE SUBMIT ALL RELEVANT REVIEW DOCUMENTATION TO INCLUDE BUT NOT LIMITED TO RADIOGRAPHS, FILMS, X-RAYS

ORTHODONTIC QUESTIONS ONLY

Post Treatment Stabilization Yes No Total Fee for Requested Treatment \$ _____

Recommendations for Comprehensive Orthodontic Treatment

Orthodontic-Frequency of Visits Weekly Bi-Weekly Monthly Other

If Other, please specify

MUST MEET ALL CRITERIA:

- Radiographs: panoramic, cephalometric and cephalometric tracing
- Dental Molds: Upper and Lower study casts trimmed to the correct occlusion
- Photos: Intra and Extra Oral
- Treatment plan to include findings, diagnosis, prognosis, length of treatment, phases of treatment and specific code requested.

MUST MEET AT LEAST ONE OF THE FOLLOWING CRITERIA:

- Overjet in excess of 7mm
- Severe malocclusion associated with dento-facial deformity
- True Anterior open bite
- Full cusp classification from normal (Class II or Class III)
- Palatal impingement of lower incisors into the palatal tissue causing tissue trauma
- Cleft Palate, congenital or developmental disorder
- Anterior Crossbite (2 or more teeth, in cases where gingival stripping from the crossbite is demonstrated and not correctable by limited orthodontic treatment.)
- Unilateral posterior crossbite with deviation or bilateral posterior crossbite involving multiple teeth including at least one molar
- True Posterior open bite(Not involving partially erupted teeth or one or two teeth slightly out of occlusion and not correctable by habit therapy)
- Impacted teeth (excluding 3rd molars) cuspids and laterals only