COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE PRIOR AUTHORIZATION UNIT

ORTHODONTIC DECISION CHECKLIST

RECIPIENT NAME	RECIPIENT I.D. NUMBER
1. PERMANENT TEE	TH FULLY ERUPTED
☐ YES ☐ NO	
. 0\/EDDITE	
2. OVERBITE YES NO	D Palatal Impingement of lower incisors on the upper gingival mucosa.
☐ YES ☐ NO	
3. OPEN-BITE	
☐ YES ☐ NO	·
L TES L NO	7 Fosterior open-bite.
4. OVERJET	
☐ YES ☐ NO	At least 9mm overjet (measuring from facial surface of lower incisor to incisal of upper incisor).
5. CROSS-BITE YES NO	O Anterior locked lingual tooth/teeth.
☐ YES ☐ NO	
☐ YES ☐ NO	
6. IMPACTIONS	position and degree
Please explain p	position and degree
7. BLOCKED OUT CA	
☐ YES ☐ NO)
8. HYPERTROPHIC (GINGIVAE
	D Direct result of excessive crowding.



COSMETIC ORTHODONTICS IS NOT COMPENSABLE IN D.P.W. REGULATIONS

Please use the criteria on the opposite side at the initial examination of the patient to determine whether a handicapping malocclusion exists. If there is a handicapping malocclusion, models and x-rays can be taken and submitted to the Prior Authorization unit.

PLEASE COMPLETE THE FOLLOWING Description of patient's condition and diagnosis:	
Description of patient's condition and diagnosis.	
Treatment Plan:	
Remarks:	