COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
PRIOR AUTHORIZATION UNIT

ORTHODONTIC DECISION CHECKLIST

RECIPIENT NAME	RECIPIENT I.D. NUMBER

1. PERMANENT TEETH FULLY ERUPTED

☐ YES ☐ NO

2. OVERBITE

☐ YES ☐ NO Palatal Impingement of lower incisors on the upper gingival mucosa.

☐ YES ☐ NO Maxillary incisors opposite to gingival mucosa of lower.

3. OPEN-BITE

☐ YES ☐ NO Anterior open-bite.

☐ YES ☐ NO Posterior 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 Anterior locked lingual tooth/teeth.

☐ YES ☐ NO Two or more teeth in same arch in posterior segment.

☐ YES ☐ NO Upper posterior tooth/teeth in buccal cross-bite to lower.

6. IMPACTIONS

Please explain position and degree

7. BLOCKED OUT CANINES

☐ YES ☐ NO

8. HYPERTROPHIC GINGIVAE

☐ YES ☐ NO Direct result of excessive crowding.

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IMPORTANT

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:

Treatment Plan:

Remarks: