TennCare Dental Orthodontic Readiness Necessity Form

This form is required to be submitted with documentation as outlined (Orthodontic Treatment Criteria) of the TennCare Provider Office Reference Manual to determine if the patient qualifies for orthodontic treatment in the TennCare program. Failure to complete this form in its entirety may result in a denied request.

As a condition for coverage, orthodontic treatment must be proved medically necessary. Medical Necessity can be established upon:

- The substantiated presence of one of the three medical conditions listed below or a DentaQuest-scored Malocclusion Severity Assessment (MSA) result of 28 or higher. (Important note: An MSA score is never used to deny orthodontic treatment.)

Patient Information		
Name (First & Last):	Date of Birth:	SS or ID#:
Address:	City, State, Zip:	Area Code & Phone Number:
Referring DDS or Pediatric Dentist:	Address:	City and State:

1. **Tissue laceration from a deep impinging overbite.**
   - ☐ YES Along with this form, please submit intraoral photographs or study casts, which document the laceration.
   - ☐ NO

2. A **nutritional deficiency** has been diagnosed by a licensed physician, and the substantiated nutritional deficiency cannot be corrected without orthodontic treatment.
   - ☐ YES Along with this form, please submit supporting documentation from the physician who diagnosed or attempted to treat patient's nutritional deficiency.
   - ☐ NO
   - ☐ DON'T KNOW

3. **Speech pathology** has been diagnosed by a licensed and certified Provider, and the substantiated speech pathology cannot be corrected without orthodontic treatment.
   - ☐ YES Along with this form, please submit supporting documentation from the patient's speech pathologist.
   - ☐ NO
   - ☐ DON'T KNOW

I certify, by my signature, that all responses on this form are true and I agree with the following statements:

1. I have consulted with the referring general dentist or pediatric dentist and the patient has completed all restorative treatment necessary to begin orthodontic treatment.
2. I have personally examined the patient and the patient's oral hygiene and periodontal condition are within acceptable limits for orthodontic treatment.
3. I agree to submit my complete orthodontic record and treatment notes on the patient within 3 days of a request made by DentaQuest or TennCare, if denials of authorization by DentaQuest results in an appeal or anytime such records are requested by DentaQuest or TennCare.

Orthodontist's signature _____

Orthodontist's name _____

Street Address _____

City_____**State** _____**Date** _____

Submit to: DentaQuest-TennCare, Ortho Readiness, PO Box 2906, Milwaukee, WI 53201-2906 800.417.7140

Any modification of this form will not be accepted.

This form may be downloaded from the DentaQuest website: www.dentaquest.com TennCare Dental Provider ORM Oct 2013