

PRIOR AUTHORIZATION for ORTHOGNATHIC SURGERY

For authorization, please complete this form, include patient chart notes to document information and FAX to the PEHP Prior Authorization Department at (801) 366-7449 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Member & Provider Services at (801) 366-7555 or toll free at (800) 753-7490.

Section I: PATIENT INFORMATION

Date Requested:	Name (Last, First MI):		DOB:	Age:	PEHP ID #:
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Section II: PROVIDER(S) INFORMATION

Rendering Provider:		Rendering Provider Address:			
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Provider NPI #:	Provider TIN #:	Contact Person:	Phone: ()	Facsimile: ()	Email Address:
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Facility/Hospital Name:	Facility/Hospital Address:				
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Facility NPI #:	Facility TIN #:	Contact Person:	Phone: ()	Facsimile: ()	Email Address:
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Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: Please check.	Requested Date(s) of Service: From: _____ To: _____	Place of Service: Please check. <input type="checkbox"/> Ambulatory Surgical Center <input type="checkbox"/> Inpatient <input type="checkbox"/> Office <input type="checkbox"/> Outpatient
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Primary Diagnosis/ICD-10 Code (s):	Secondary Diagnosis/ICD-10 Code (s):
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A. Service (s) Requested: *Please list all requested services/codes regardless of pre-authorization requirement. Unlisted codes cannot be pre-authorized.*

Procedure/Service: _____	CPT/HCPCS code: _____

(Please check indication)	QUESTION	YES	NO	COMMENTS/NOTES
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A. <input type="checkbox"/> Maxillary and/or Mandibular Facial Skeletal Deformities Associated with Masticatory Malocclusion / Anteroposterior Discrepancies:				
1. Is the skeletal deformity contributing to significant masticatory dysfunction?		<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the deformity so severe that it precludes adequate treatment through dental therapeutics and orthodontics??		<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the maxillary/mandibular incisor relationship overjet 5 millimeter (mm) or more, or a 0 to negative value (norm is 2mm)?		<input type="checkbox"/>	<input type="checkbox"/>	
4. Is the maxillary/mandibular anteroposterior molar relationship discrepancy 4 mm or more (norm 0 to 1 mm)?		<input type="checkbox"/>	<input type="checkbox"/>	

B. <input type="checkbox"/> Maxillary and/or Mandibular Facial Skeletal Deformities Associated with Masticatory Malocclusion / Vertical Discrepancies:				
1. Is the skeletal deformity contributing to significant masticatory dysfunction?		<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the deformity so severe that it precludes adequate treatment through dental therapeutics and orthodontics??		<input type="checkbox"/>	<input type="checkbox"/>	
3. For open bite, is there vertical overlap of anterior teeth greater than 2 mm?		<input type="checkbox"/>	<input type="checkbox"/>	
4. For open bite, is the unilateral or bilateral posterior open bite greater than 2 mm?		<input type="checkbox"/>	<input type="checkbox"/>	
5. Does the patient have a deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch?		<input type="checkbox"/>	<input type="checkbox"/>	
6. Does the patient have supraeruption of a dentoalveolar segment due to lack of opposing occlusion creating dysfunction not amendable to conventional prosthetics?		<input type="checkbox"/>	<input type="checkbox"/>	

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Name (Last, First MI):		DOB:	Age:	PEHP ID #:		
(Please check indication)		QUESTION (cont'd)		YES	NO	COMMENTS/NOTES
C. <input type="checkbox"/> Maxillary and/or Mandibular Facial Skeletal Deformities Associated with Masticatory Malocclusion / Transverse Discrepancies:						
1. Is the skeletal deformity contributing to significant masticatory dysfunction?		<input type="checkbox"/> <input type="checkbox"/>				
2. Is the deformity so severe that it precludes adequate treatment through dental therapeutics and orthodontics??		<input type="checkbox"/> <input type="checkbox"/>				
3. Is the total bilateral maxillary palatal cusp to mandibular fossa discrepancy 4mm or greater?		<input type="checkbox"/> <input type="checkbox"/>				
4. Is there a unilateral discrepancy of 3 mm or greater given normal axial inclination of the posterior teeth?		<input type="checkbox"/> <input type="checkbox"/>				
D. <input type="checkbox"/> Maxillary and/or Mandibular Facial Skeletal Deformities Associated with Masticatory Malocclusion / Asymmetries:						
1. Is the skeletal deformity contributing to significant masticatory dysfunction?		<input type="checkbox"/> <input type="checkbox"/>				
2. Is the deformity so severe that it precludes adequate treatment through dental therapeutics and orthodontics??		<input type="checkbox"/> <input type="checkbox"/>				
3. Is there an anteroposterior, transverse, or lateral asymmetry greater than 3 mm with concomitant occlusal asymmetry?		<input type="checkbox"/> <input type="checkbox"/>				
E. <input type="checkbox"/> Facial Skeletal Discrepancies Associated with Sleep Apnea, Airway Defects, & Soft Tissue Discrepancies:						
1. Is there documentation that mandibular and maxillary deformity are contributing to airway dysfunction?		<input type="checkbox"/> <input type="checkbox"/>				
2. Is the dysfunction not amendable to non-surgical treatments?		<input type="checkbox"/> <input type="checkbox"/>				
3. Has it been shown that orthognathic surgery will decrease airway resistance and improve breathing? <i>For example, studies demonstrate that persons with vertical hyperplasia of the maxilla have an associated increase in nasal resistance. After orthognathic surgery, such individuals routinely demonstrate decreases in airway resistance and improved respiration.</i>		<input type="checkbox"/> <input type="checkbox"/>				
F. <input type="checkbox"/> Obstructive Sleep Apnea (OSA):						
1. Is jaw realignment surgery being requested because the underlying craniofacial skeletal deformity is contributing to obstructive sleep apnea (OSA)??		<input type="checkbox"/> <input type="checkbox"/>				
2. Has the patient failed all other treatment approaches for obstructive sleep apnea (OSA)?		<input type="checkbox"/> <input type="checkbox"/>				
G. <input type="checkbox"/> Temporomandibular Joint Pathology:						
1. Is orthognathic surgery being requested to correct temporomandibular joint disease?		<input type="checkbox"/> <input type="checkbox"/>				
2. Is orthognathic surgery being requested to correct myofascial pain dysfunction?		<input type="checkbox"/> <input type="checkbox"/>				
H. <input type="checkbox"/> Speech Impairments:						
1. Is orthognathic surgery being requested for treatment of speech impairments accompanying severe cleft deformity?		<input type="checkbox"/> <input type="checkbox"/>				
2. Is orthognathic surgery being requested for correction of articulation disorders or other impairments in the production of speech?		<input type="checkbox"/> <input type="checkbox"/>				
3. Is orthognathic surgery being requested for correction of distortions within the sibilant sound class or for other distortions of speech quality (e.g., hyper-nasal or hypo-nasal speech)?		<input type="checkbox"/> <input type="checkbox"/>				
I. <input type="checkbox"/> Unaesthetic Facial Features and Psychological Impairments:						
1. Is orthognathic surgery being requested to correct an unaesthetic facial feature?		<input type="checkbox"/> <input type="checkbox"/>				
2. Is orthognathic surgery being requested to correct an unaesthetic facial feature associated with a psychological disorder ?		<input type="checkbox"/> <input type="checkbox"/>				
3. Will a mentoplasty or genial osteotomy/ostectomy (chin surgery) be performed as an isolated procedures to address genial hypoplasia, hypertrophy, or asymmetry		<input type="checkbox"/> <input type="checkbox"/>				
Additional Comments:						
By submitting this form, I attest that the information provided is true and accurate to the best of my knowledge.						
*Please fax completed form and medical records to 801-366-7449.						