Utilization Management
Phone: 1-877-284-0102 Fax: 1-800-510-2162

Mandibular/Maxillary (Orthognathic) Surgery Precertification Review

Date: _____ Reference #: _____(provided after initial review)
A Utilization Management representative will fax you a reference number by the next business day after receiving this completed form. This reference number does not indicate an approval or denial of benefits, but only proof that the Plan has been notified. This information will be forwarded to the Plan's Managed Care Department. If you have any questions, please call HealthLink at 1-877-284-0102.

Physician Information

Admitting Physician Name: _____

Group Practice Name: _____

Address: _____

Phone: _____

Fax: _____

TIN: _____

Patient Information

Patient Name: _____

ID Number: _____

Patient DOB: _____

Address: _____

Phone: _____

Hospital/Facility Information

Hospital/Facility Name: _____

Address: _____

Phone: _____

Fax: _____

Treatment Information

Primary Diagnosis: _____

Diagnosis (ICD-10) Code: _____

Primary Procedure: _____

Procedure (ICD-10) Code: _____

Procedure Date: _____

Admission Date: _____

Anticipated Length of Stay: _____

Bed Type: ☐ Medical ☐ Surgical ☐ ICU/CCU ☐ Other (specify) _____

Type Admission: ☐ Inpatient ☐ Outpatient/23 hour observation

Please select the reason surgery is being requested and answer applicable questions.

☐ Dysphagia (if selected, questions below require answers):

1. Does the member have difficulty chewing food? ☐ YES ☐ NO

   If yes, due to: ☐ incomplete mastication ☐ ability to chew only soft food ☐ nutrition through liquid food

2. Have other causes for dysphagia been ruled out by history, physical exam, and appropriate diagnostic studies? ☐ YES ☐ NO
3. How many months has the member had dysphagia? _____

☐ Speech Abnormalities (if selected, questions below require answers):

1. Has a speech therapist determined the member's speech abnormality is due to malocclusion?

   ☐ YES ☐ NO
2. Has the member tried orthodontia? ☐ YES ☐ NO
3. Has the member tried six (6) months of speech therapy? ☐ YES ☐ NO

☐ Masticatory Dysfunction or Malocclusion (if selected, questions below require answers):

1. Is the member 18 years of age or older? ☐ YES ☐ NO

   If no, additional information required regarding skeletal growth completion either by long x-ray or serial cephalometric showing no change in facial or long bone over a three (3) – six (6) month period.
2. What is the horizontal overjet (mm) for the maxillary/mandibular incision relationship? (norm is 2mm) _____
3. What is the mandibular/maxillary anteroposterior molar relationship discrepancy (mm)? _____
4. Does the member have any vertical discrepancies such as vertical facial deformity? ☐ YES ☐ NO

   If yes, please explain: _____

   _____

   _____
5. Does the member have vertical overlap of anterior teeth with open bite? ☐ YES ☐ NO
6. Is the unilateral or bilateral posterior open bite greater than 2mm? ☐ YES ☐ NO
7. Does the member have a deep overbite that causes impingement or irritation of buccal or lingual soft tissues of the opposing arch? ☐ YES ☐ NO
8. Is there supra-eruption of the dentoalveolar segment due to lack of occlusion due to the vertical discrepancy? ☐ YES ☐ NO
9. Does the member have transverse skeletal discrepancy that is 2 or more standard deviations from the published norm? ☐ YES ☐ NO

   If yes, what is the transverse discrepancy measurement? _____
10. Is the total bilateral maxillary palatal cusp to mandibular fossa discrepancy of 4mm or greater or the unilateral discrepancy 3mm or greater, given normal axial inclination of the posterior teeth? ☐ YES ☐ NO
11. Are anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry? ☐ YES ☐ NO
12. Does the conditional involve treatment of skeletal deformity? ☐ YES ☐ NO

    If yes, please submit computed tomography (CT), magnetic resonance imaging (MRI) or x-ray.
13. Has the member suffered intra oral trauma due to malocclusion while chewing? ☐ YES ☐ NO

    If yes, please explain trauma that is being caused: _____

    _____

    _____

Discharge Information

If known, please supply the following:

Discharge Planner Name: _____

Phone: _____

Anticipated Discharge Date: _____

Anticipated Discharge Needs: ☐ Rehab ☐ SNF ☐ HHC* ☐ Home Infusion*

**Preferred Providers available* ☐ DME* ☐ Outpatient PT ☐ Outpatient OT ☐ HOSPICE

Additional Comments

_____

_____

Provider Contact Information

Contact Person: _____

Title: _____

Phone: _____

Fax: _____