CareSource

Evaluation Form for Comprehensive Orthodontic Treatment

Member Name: _____ **CareSource ID #:** _____

Member's Birthdate: _____ **Exam Date:** _____

CONDITIONS

If you check conditions 1-3, you do not need to document any other conditions. Complete a narrative of findings supporting functional concerns and submit this form with required Work-up.

1. _____ Cleft Palate Deformities
2. _____ Severe Traumatic Deviations (e.g. accidental loss of premaxilla, gross pathology)
3. _____ Facial discrepancy requiring combined orthodontics and orthognathic surgery
4. _____ Overbite as a percentage (%) _____%
5. _____ Deep impinging overbite w/2 or more teeth causing damage visible in Workup
6. _____ Overjet in mm _____
7. _____ Reverse overjet in mm _____
8. _____ Anterior Open Bite – Tooth # (mm) _____
9. _____ Anterior Crowding
   i. Mandibular Space needed in mm _____
   ii. Maxillary Space needed in mm _____
10. _____ Anterior Spacing
    i. Mandibular in mm _____
    ii. Maxillary in mm _____
11. _____ Anterior Crossbite – Must be more than two teeth in maxillary arch
    i. Tooth numbers _____
12. _____ Posterior Crossbite – More than two teeth with one being a molar or Brodie bite
    i. Tooth numbers _____
13. _____ Class II _____ Class III _____ malocclusion – at least one full tooth
14. _____ Impacted Cuspids, bicuspids* or incisors that will not erupt without surgical intervention
    i. Tooth numbers _____
15. _____ Congenitally missing teeth
    i. Tooth numbers _____
16. _____ Speech problems or History of Speech Therapy*
17. _____ Temporomandibular Joint Involvement (Complete TMD Workup Form)
18. _____ Psychosocial Concerns**
19. _____ Periodontal Concerns***

* Provide documentation from speech therapist, school nurse/guidance counsellor or other professional who has dealt with the member's speech concerns

** Provide documentation of the nature of the concern, when it occurred, who it was reported to and the response from the party (e.g. /school principal or health professional's evaluation and follow-up)

*** Provide periodontal charting demonstrating the concerns and other preventive treatment history

I certify that I am the treating health partner and that the medical necessity information is true and accurate

Treating Dentist Signature:	Date:

OH-P-1001