West Virginia Children's Health Insurance Program
Request for Precertification for Comprehensive Orthodontic Treatment

Patient Name: _____ DOB: _____

I.D. Number: _____ Exam Date: _____

Provider Name: _____ Provider Phone: _____

Provider Fax: _____ NPI # _____

Provider Address: _____

City: _____ State: _____ ZIP: _____

Complete Diagnosis:

Current Treatment Status:

Recommendation for Orthodontic Treatment:

Orthodontic Treatment – Procedure Code _____

Post-Treatment Stabilization – Procedure Code _____

Total Fee (Usual and Customary Fee) _____

Precertification from WVCHIP assures claims will be paid when submitted EXCEPT when the child dis-enrolls from the plan on or before the date of service.* If the precertification request is denied, the parent or guardian is responsible for paying for procedures completed without a precertification approval.

***It is the provider's responsibility to verify eligibility of WVCHIP member card by calling the WVCHIP Helpline at 1-877-982-2447.**

Information Required for Assessing Handicapping Malocclusion

1. Overjet_____ 2. Overbite_____
3. Molar Relationship R_____ L_____
4. Skeletal Relationship I_____ II_____ III_____
5. Missing Teeth_____
6. Impacted Teeth _____
7. Crowding_____
8. Cleft Palate Yes_____ No_____
9. Cross Bite
   - A – Anterior Teeth _____
   - B – Posterior Teeth L_____
   - C – Posterior Teeth R_____
10. Open Bite
    - A – Anterior Teeth_____
    - B – Posterior Teeth L_____
    - C – Posterior Teeth R_____
11. Comments: _____

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Send precertification request form and documentation (panoramic Film; cephalometric tracing; cephalometric x-ray; photographs – a standard series of 5 Intra and 3 Extra Oral photographs that meets the American Board of Orthodontics standards, and treatment plan, including findings, diagnosis, prognosis, length of treatment, and phases of treatment) to:

WVCHIP
2 Hale Street, Suite 101
Charleston, WV 25301

_____ _____

Provider's Signature Date