MASSACHUSETTS

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Prior Authorization Request for Medically Necessary Orthodontia Services for Pediatric Essential Health Benefits

Please submit this form with the Pre-Treatment Estimate to obtain prior authorization for medically necessary orthodontia services covered under pediatric Essential Health Benefits. Electronic submission is preferred, but if you need to submit paper, please send to: Blue Cross Blue Shield of Massachusetts, PO Box 986005, Boston MA 02298

Patient Information		Orthodontist Information	
Name:		Name:	
Member ID:		Provider NPI:	
Address:		Address:	
Phone:		Phone:	
Date of birth:			

Please describe the patient's malocclusion:

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Please describe the treatment to be performed:

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For **Comprehensive cases**, please submit the following documentation with this Medically Necessary Orthodontia for Pediatric Essential Health Benefits form.

- ❑ Photographic prints (Facial, Lateral, Occlusal)
- ❑ Panoramic Radiographic Image (copy)
- ❑ ADA Pre-treatment Claim Form
- ❑ *Handicapping the Labio-Lingual Deviations* form
- ❑ Cephalometric Radiographic Image (copy)

For **interceptive cases**, please submit the following with the Pre-Treatment Estimate form in addition to this Medically Necessary Orthodontia for Pediatric Essential Health Benefits form.

- ❑ Photographic Prints (Facial, Lateral, Occlusal)