

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
PRIOR AUTHORIZATION UNIT

ORTHODONTIC DECISION CHECKLIST

RECIPIENT NAME	RECIPIENT I.D. NUMBER

1. PERMANENT TEETH FULLY ERUPTED

YES NO

2. OVERBITE

YES NO Palatal Impingement of lower incisors on the upper gingival mucosa.

YES NO Maxillary incisors opposite to gingival mucosa of lower.

3. OPEN-BITE

YES NO Anterior open-bite.

YES NO Posterior open-bite.

4. OVERJET

YES NO At least 9mm overjet (measuring from facial surface of lower incisor to incisal of upper incisor).

5. CROSS-BITE

YES NO Anterior locked lingual tooth/teeth.

YES NO Two or more teeth in same arch in posterior segment.

YES NO Upper posterior tooth/teeth in buccal cross-bite to lower.

6. IMPACTIONS

Please explain position and degree

7. BLOCKED OUT CANINES

YES NO

8. HYPERTROPHIC GINGIVAE

YES NO Direct result of excessive crowding.

