Client Treatment History Form

(For Nevada Medicaid and Nevada Check Up Orthodontic Treatment)

Process

1. A dentist must complete and submit this form to the orthodontist when referring a Nevada Medicaid or Nevada Check Up recipient for orthodontic treatment.
2. The orthodontist must submit this form to Nevada Medicaid along with the Orthodontic Medical Necessity (OMN) Form to request prior authorization for orthodontia services.
3. An orthodontist requesting prior authorization for a second phase of orthodontic treatment must obtain a Client Treatment History Form from the provider that completed the first phase of treatment. A new Client Treatment History Form for the second phase must be specific to orthodontic treatment performed by the orthodontist; a report by the regular dentist is not considered sufficient.

Limitations

Nevada Medicaid and Nevada Check Up consider orthodontic prior authorization requests when the eligible recipient is under age 21, received services from the treating dentist's office on at least two occasions on separate days and missed no more than 30% of scheduled appointments for any reason as indicated on all Client Treatment History Forms submitted (Medicaid Services Manual (MSM) Chapter 1000, Section 1003.8.A.3).

In addition, the orthodontist to perform the treatment must be enrolled as a Nevada Medicaid provider. (MSM Chapter 1000, Section 1003.19)

Client Information

Client Name:_____ Date of Birth:_____

Is the client eligible for Nevada Medicaid or Nevada Check Up benefits? ☐ Yes ☐ No

Treatment History

Complete all blanks to describe your treatment experience with this client. Submit no more than two years of dental appointment history. (MSM Chapter 1000, Section 1003.8)

Number of appointments scheduled with your office in the last two years:_____

Number of missed appointments in the last two years:_____

OR: Drop-in practices *only*, please list number of visits in the last two years:_____

Justification for referral for orthodontic treatment:

_____

_____

_____

_____

Treating Dentist's Name *(print)***:_____Phone: _____**

Treating Dentist's Signature:_____Date:_____