Orthodontia Patient Prior Authorization Form
(Codes D8010, D8020, D8030, D8040)

Date_____ Valid From _____ To _____ Referral #_____

Patient Name_____

Medical ID_____

DOB _____

Please check the box below for code requested:

- ☐ **D8010**
- ☐ **D8020**
- ☐ **D8030**
- ☐ **D8040**

Please describe the medical necessity for this service:

- ☐ This service is required for the prevention, diagnosis, treatment or amelioration of a beneficiary's disease, condition, or disorder that results in health impairments or a disability.
- ☐ The service is required to achieve age-appropriate growth and development. It improves the beneficiary's ability to participate in work or school. It contributes to the prevention, diagnosis, detection, treatment, cure, correction, reduction, or alleviation of the effects of a physical, mental, behavioral, nutritional, dental, genetic, developmental or congenital condition, injury, or disability.
- ☐ The service is required for an beneficiary to attain, maintain, or regain independence in self-care, or the ability to perform activities of daily living or improve health status.
- ☐ Please provide any additional medical necessity details for Dental Director review:

  _____

  _____

Orthodontist Signature_____Date_____

For Use By CDC Staff Only:

Referred To: _____
Address: _____
City/State _____
Zip Code: _____

Medical Necessity Review:

Revised 3/17/26