EARLY AND PERIODIC SCREENING DIAGNOSTIC AND TREATMENT (EPSDT)
COMPREHENSIVE ORTHODONTIC SCREENING

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 61 (5-2025)

Clear Fields

Name	ND Medicaid ID Number	Date of Birth	Date

(Any Age) This **immediate** referral is for a Cleft Lip or Cleft Palate. **Points are not required.**

Comments

(Age 7 to 10) This referral is a limited (formerly known as Interceptive) screening for the evaluation of orthodontic treatment based upon:

☐ Anterior Cross Bite ☐ Posterior Cross Bite ☐ Ectopic (mal-positioned incisors) ☐ Cleft Lip/Cleft Palate

Any child experiencing one or more conditions listed above may be referred to an enrolled dental provider for an evaluation without the **comprehensive** evaluation below.

Comments

(Age 10 through 20) This referral is a **Comprehensive** screening for evaluation of orthodontic treatment. Have the child position their teeth in centric position (normal bite position of the child).

CONDITION	MEASUREMENT	SCORE
Overjet	Measure overjet in mm	
Overbite	Measure overbite in mm	
Mandibular protrusion (lower front teeth)	Measure number of mm between arch protrusion, multiply by 5	
Anterior open bite	Measure number of mm at largest open space, multiply by 4	
Impacted anterior teeth (both arches)	Count number of impacted teeth, multiply by 5	
Moderate crowding of teeth	Add 2 points per arch (upper and/or lower)	
Severe crowding of teeth	Add 4 points per arch (upper and/or lower)	
Number of teeth in anterior crossbite	Add number of teeth, multiply by 2	
Number of teeth in posterior crossbite	Add number of teeth, multiply by 2	
Habits affecting arch development	Add 2 points (finger or thumb sucking, tongue thrusting)	
	Total Points	

Screener Comments

Oral Hygiene Observation

Explain Dental Caries or Restorative Needs

Date of Most Recent Dental Exam	Parent and patient are willing to comply with treatment recommendations ☐ Yes ☐ No

Children meeting the established criteria should be referred to an enrolled dental provider for further evaluation.

Note to Dental/Orthodontic Treating Provider:

Specifically for comprehensive cases: please submit a narrative description, radiographs, photos and the cephalometric film (when taken). This documentation is required in addition to the screening forms with each request, regardless of the number of points. All documentation should be submitted to the North Dakota Medicaid Program Dental Consultant for review. The child must be North Dakota Medicaid enrolled at the beginning of the treatment phase.

Screener	Title