ORTHODONTICS REPORT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SPECIAL HEALTH SERVICES UNIT
SFN 762 (8-2023)

NOTE TO ORTHODONTIST: This report is needed to determine eligibility for handicapping malocclusion but is not needed for malocclusion related to cleft lip and/or palate. SHS does not require the Prior Treatment Authorization Request (PTAR) form.

Name of Patient			Date of Birth
Name of Parent			
Address	City	State	ZIP Code

Mark the criteria that applies to the client. For consideration the client must present with two of the bolded criteria or three of the standard criteria listed below.

Criteria	Comments
☐ 1. Excess overjet of 7 millimeters or greater	
☐ 2. Deep anterior overbite of 90% or greater	
☐ **3. Severe crowding**	
☐ 4. Severely malposed maxillary anterior teeth resulting in disfigurement	
☐ 5. Ectopic eruption of anterior teeth	
☐ **6. Underbite of 3 millimeters or greater**	
☐ **7. Impacted anterior teeth**	
☐ 8. Anterior open bite of 4 millimeters or greater	
☐ 9. Habits such as tongue thrusting or thumb sucking	
☐ 10. Posterior crossbite	

ESTIMATED COST AND LENGTH OF CARE

Full Fee	
Initial Fee	
Monthly Fee	
Expected Length of Treatment	

COMMENTS

Signature of Orthodontist	Printed Name of Orthodontist	Date

DISTRIBUTION: Submit original to Special Health Services Unit. Retain a copy for your records.