



DEPARTMENT OF HEALTH & SOCIAL SERVICES  
DIVISION OF SOCIAL SERVICES

**PRIOR AUTHORIZATION REQUEST  
FOR  
INTERCEPTIVE ORTHODONTICS**

Prior Authorization for interceptive orthodontics is requested as follows:

Client Name: \_\_\_\_\_  
Client ID Number: \_\_\_\_\_  
Client Diagnosis: \_\_\_\_\_  
Attach Client Treatment Plan: \_\_\_\_\_  
\_\_\_\_\_

Interceptive Orthodontic Service to be Performed (D8060): \_\_\_\_\_  
Provider's Fee for the Procedure: \_\_\_\_\_  
Tentative Date of Service: \_\_\_\_\_

**Please Note:** Include panorex and photographs. The approval of interceptive orthodontics does not include approval for further comprehensive orthodontic care. Reimbursement for this service covers the actual treatment plan and all related visits. The child must be Medicaid eligible on the date the interceptive orthodontic service is performed in order to be paid by the State Medicaid Program.

Provider Group Name: \_\_\_\_\_  
Provider Group ID Number: \_\_\_\_\_  
Performing Provider Name: \_\_\_\_\_  
Performing Provider ID Number: \_\_\_\_\_

\_\_\_\_\_  
Authorized Signature \_\_\_\_\_  
Date  
\_\_\_\_\_  
Provider Phone Number \_\_\_\_\_  
Provider Fax Number

**Please e-mail to: [gabrielle.hilliard@state.de.us](mailto:gabrielle.hilliard@state.de.us)**

**OR Mail to:  
Dental PA Unit  
Division of Social Services  
P.O. Box 906  
New Castle, DE 19720**