806 KAR 17:090
MATERIAL INCORPORATED BY REFERENCE
TEMPOROMANDIBULAR JOINT DISORDER (TMJ)
NONSURGICAL TREATMENT PREAUTHORIZATION REQUEST FORM
(Please type or print legibly)

Date of Request___________________________

PATIENT INFORMATION:	PROVIDER INFORMATION:
Name________________________________	Name________________________________
Policy or Claim # _______________________	Provider Number_______________________
Street________________________________	Street________________________________
City/State ____________________________	City/State ____________________________
Zip Code_____ Phone (___)_______________	Zip Code_____ Phone (___)_______________

*******************************DEAR PROVIDER*****************************
PLEASE COMPLETE AND SIGN THE FOLLOWING, FOR PREAUTOIZATION REVIEW OF ANTICIPATED CRANIOMADIBULAR/TEMPOROMANDIBULAR JOINT TREATMENT.

1. Does the patient have a history of pain or dysfunction of one month or greater?

   _____ Yes _____ No How long? ____

   Continuous _____ Intermittent_____ Comments___________________________________

   ____

2. Does the patient exhibit signs or symptoms of TMJ Disc Disorder?

   _____ Yes _____ No (If yes, describe the signs or symptoms with proper ICD-9-CM diagnostic number)

   ____Code___________________

   ____Code___________________

3. Does the patient exhibit signs or symptoms of Muscle Disorder?

   _____ Yes _____ No (If yes, describe the signs or symptoms with proper ICD-9-CM diagnostic number)

   ____Code___________________

   ____Code___________________

4. In the absence of pain, are the signs and symptoms indicated above accompanied by functional limitations? _____ Yes _____ No (If yes, please document below)

Maximal Incisal Opening: _____mm

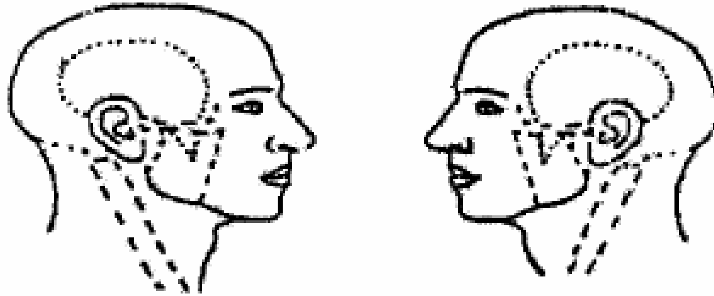
Incisal Opening Without Pain: _____mm

Maximal Lateral Movements: Right _____mm Left _____mm

Lateral Movement Without Pain: Right _____mm Left _____mm

Deviation Normal Opening: Right _____mm Left _____mm

5. Indicate with an "X" on the diagrams below where the patient exhibited pain on initial examination.



6. Diagnostic tests that are requested (i.e. arthrograms, tomograms, and other imaging studies). List and include ADA or CPT code numbers.

____Code__________________

____Code__________________

7. What mode of treatment you propose? (i.e., splint therapy, arthrocentesis, physical therapy). List and include ADA or CPT code numbers.

____Code__________________

____Code__________________

____Code__________________

8. Do you contemplate irreversible alterations of the occlusion as a result of your treatment?

_____ Yes _____ No (If yes, please describe)________________________________

____

9. Indicate you anticipated total fee per procedure, including follow-up care.

Procedure:___________________________________ Fee_____________________

Procedure:______________________________________ Fee______________________

Procedure:______________________________________ Fee______________________

Total Fee______________________

10. Date treatment was initiated or date of anticipated initiation.

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Additional Comments: ____

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I acknowledge that the above is true and accurate.

____

Provider's Signature