Member Name :	ID#:	D.O.B.

PRELIMINARY ***HANDICAPPING*** **MALOCCLUSION ASSESSMENT RECORD**

(Part III: Sections "E", "F" and "G" are completed by the orthodontist.

EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM

Please mark the affected tooth numbers.)

E. INTRA-ARCH DEVIATION

SCORE TEETH AFFECTED ONLY		MISSING	CROWDED	ROTATED	SPACING		NO.	POINT VALUE	SCORE
					OPEN	CLOSED			
MAXILLA	Ant	7 8 9 10	7 8 9 10	7 8 9 10	7 ^8 ^9^10	7 8 9 10		X 2	
	Post	3 4 5 6 14 13 12 11	3 4 5 6 14 13 12 11	3 4 5 6 14 13 12 11	3 4 5 6 14 13 12 11	3 4 5 6 14 13 12 11		X 1	
MANDIBLE	Ant	23 24 25 26	23 24 25 26	23 24 25 26	23^24^ 25^26	23 24 25 26		X 1	
	Post	19 20 21 22 30 29 28 27	19 20 21 22 30 29 28 27	19 20 21 22 30 29 28 27	19 20 21 22 30 29 28 27	19 20 21 22 30 29 28 27		X 1	
Ant = anterior teeth (4 incisors). Post = posterior teeth (including canine, premolars, and first molar). No. = number of teeth affected.							SECTION SCORE		

F. INTER-ARCH DEVIATION **1. Anterior Segment**

SCORE MAXILLARY TEETH AFFECTED ONLY EXCEPT OVERBITE*	OVERJET	OVERBITE(MAX 4 TEETH)	CROSSBITE	OPENBITE	NO.	POINT VALUE	SCORE
	7 8 9 10	7 8 9 10 23 24 25 26	7 8 9 10	7 8 9 10		X 2	
	*Score maxillary or mandibular incisors. No. = number of teeth affected.				SECTION SCORE		

2. Posterior Segments

SCORE TEETH AFFECTED ONLY	RELATE MANDIBULAR TO MAXILLARY TEETH				SCORE AFFECTED MAXILLARY TEETH ONLY				NO.	POINT VALUE	SCORE
	DISTAL		MESIAL		CROSSBITE		OPENBITE				
	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT			
Canine										X 1	
1st Premolar										X 1	
2nd Premolar										X 1	
1st Molar										X 1	
									SECTION SCORE		
									GRAND TOTAL		

G. OTHER DEVIATIONS (use additional sheet if necessary)

The Department shall consider additional information of a substantial nature about the presence of other severe deviations affecting the mouth and underlying structures. Other deviations shall be considered severe if, left untreated; they would cause irreversible damage to the teeth and underlying structures. Is there presence of other severe deviations affecting the mouth and underlying structures? (If any, comment below). ☐Y / ☐ N

CRITERIA FOR APPROVAL OF INTERCEPTIVE ORTHODONTIC TREATMENT

Deep impinging overbite (lower incisors hit palatal tissue behind upper incisors or upper incisors hit labial tissue of lower incisors) ☐ Y / ☐ N
Functional Deviation - Midline shift of at least a half lower incisor with unilateral crossbite ☐ Y / ☐ N
Class III Malocclusion - Lower jaw growth exceeds growth of upper jaw with a negative ANB difference and the 4 upper incisors are in crossbite ☐Y / ☐ N
Gingival Recession - Anterior crossbite which causes gingival recession of 2 to 3 millimeters as compared to adjoining teeth as evidenced on study models ☐ Y /☐ N
Severe overjet of more than 9 millimeters ☐ Y / ☐ N
Open Bite - Minimum of 5 millimeters, or severe protrusion of at least 6 millimeters with anterior spacing present ☐ Y /☐ N
Anterior impacted tooth or impacted canine present ☐ Y / ☐ N

Records Submitted: ☐ FMS ☐ Panorex ☐ Models ☐ Photographs ☐ Clads ☐ Other: _____

Date of Records: _____

Comments:

ASSESSMENT RECORD Prepared by:

Signature of Reviewer **Date**

Printed Name of Reviewer

Please submit your completed Assessment, diagnostic materials and claim form to:

Orthodontic Case Review
C/O CT Dental Health Partnership
195 Scott Swamp Road
Farmington, CT 06032

Rev 06/06/2022