South Dakota Medicaid Pre-Orthodontic Certification Form

South Dakota Medicaid requires this form to be completed by the patient's dental home prior to approval for orthodontic services. Form should be given by the patient or dentist to the orthodontic service provider before patient is assessed for orthodontic treatment.

Patient Name: _____DOB:_____Recipient ID:_____

Parent or Guardian Name: _____

Address: _____

Mobile Phone: _____Home Phone: _____Work Phone: _____

Dental Office Name: _____

Dentist: _____

Required Pre-Orthodontic Criteria

Patient must meet all 3 criteria in order to be considered for orthodontic coverage:

Check all that apply:

- ☐ Patient had at least 1 preventive exam and other recommended preventive services in the last 12 months
- ☐ Patient exhibits good oral hygiene practices at home
- ☐ Patient is up to date with restorative work

CLEAR

Additional comments:

Signature Date

- Completion of form does not guarantee orthodontic coverage
- Office should retain a copy for patient record
- Form becomes invalid one year after date of dentist signature

DSS Strong Families - South Dakota's Foundation and Our Future

DELTA DENTAL®