

# Client Treatment History

(For Nevada Medicaid and Nevada Check Up Orthodontic Treatment)

## Purpose/Procedure

1. A dentist must complete and submit this report to the orthodontist when referring a Nevada Medicaid or Nevada Check Up recipient for orthodontic treatment.
2. The orthodontist must submit this report to Hewlett Packard Enterprise with a prior authorization request for orthodontia services.
3. The treating orthodontist must complete and submit a new Client Treatment History when requesting prior authorization for a second phase of orthodontic treatment.

## Limitations

Nevada Medicaid and Nevada Check Up consider orthodontic prior authorization requests when this form shows the eligible recipient is under age 21, received treatment from the treating dentist's office on at least ~~two~~four occasions and missed no more than 30% of scheduled appointments for any reason in a 24-month period (MSM Chapter 1000, Section 1003.8.A.2).

In addition, the orthodontist to perform the treatment must be enrolled with Hewlett Packard Enterprise as a Nevada Medicaid provider. (MSM Chapter 1000, Section 1003.8.A.4)

## Client Information

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Is the client eligible for Nevada Medicaid or Nevada Check Up benefits?  Yes  No

## Treatment History

Complete all blanks to describe your treatment experience with this client. Submit no more than three years of dental appointment history. (MSM Chapter 1000, Section 1003.8.A.2)

Date of the client's first treatment visit with your office: \_\_\_\_\_

Date of the client's last treatment visit with your office: \_\_\_\_\_

Number of appointments scheduled with your office (drop-in practices write "N/A" here): \_\_\_\_\_

Number of missed appointments (drop-in practices write "N/A" here): \_\_\_\_\_

Reason you believe this client will benefit from orthodontic treatment:

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Treating Dentist's Name (print): \_\_\_\_\_ Phone: \_\_\_\_\_

Treating Dentist's Signature: \_\_\_\_\_ Date: \_\_\_\_\_