Clear Form

Minnesota Department of **Human Services**

DHS-6119-ENG 8-11

Minnesota Health Care Programs

TMD Treatment Authorization Form

Use this form in addition to the MN–ITS Authorization Request transaction or the Authorization Form (DHS-4695) to request authorization for TMD treatment. Fax this form with any additional or required documentation to the medical review agent.

Recipient Information

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	MHCP ID NUMBER

Provider Information

PROVIDER NAME	NPI/UMPI
CONTACT NAME	PHONE NUMBER ( )

Describe the recipient's pertinent medical and dental health history; including relevant family history, such as arthritis, generalized joint pain, past history of trauma.
List current symptoms, including location, onset, quality, frequency, intensity and duration of all symptoms.
Describe aggravating (such as nail biting) and alleviating (such as heat) factors.

Describe exam findings, such as ROM of mandible, TMJ noises, palpitation results of TMJ and muscles.

Does the diagnosis include:

Temporomandibular internal derangement (TMJ ID)? ☐ Yes ☐ No

If yes, what stage with or without reduction?

TMJ arthritis/degenerative joint disease? ☐ Yes ☐ No

If yes, describe.

Describe past history of TMJ treatment, if any, including length of previous treatment and problems. If surgical treatment, include type of surgery (such as orthognathic), joint revisions with or without implants and the type of implant used).

Proposed Treatment Plan

Describe mode of treatment.
Describe the reason this treatment was chosen.

If using a splint, complete the following:

A. Identify the common generic name of the splint as used in current scientific literature.

_____

B. Indicate the number of hours per day the splint will be worn. _____ hours per day.

If multiple hours per day, estimate the length of each frequency. _____

C. Indicate the length of time the splint will be used (days, months, etc.). _____

D. Indicate if the splint has full occlusal coverage. ☐ Yes ☐ No

E. Indicate if the splint will be placed on the: ☐ Maxillary arch ☐ Mandibular arch

F. Indicate if the patient will eat with the splint. ☐ Yes ☐ No

G. Indicate if the splint changes the position of the mandible relative to the maxilla. ☐ Yes ☐ No

If yes, indicate if the splint is to permanently change the maxillary/mandibular relationship ☐ Yes ☐ No

If yes, indicate how far anteriorly the mandible will be positioned and what procedures will be necessary to re-establish posterior tooth contact/function.

H. Indicate if physical therapy will be required. ☐ Yes ☐ No

I. Indicate if you anticipate a phase II treatment plan. ☐ Yes ☐ No

SIGNATURE	DATE