SoonerCare

Referral for Orthodontic Treatment

Only OHCA DEN-2 is accepted. Any altered form by the provider will be rejected.

REFERRING DENTIST:

REFERRING DENTIST NPI:

TELEPHONE:

FAX:

EMAIL:

SOONERCARE MEMBER:

SOONERCARE RID:

ADDRESS:

TELEPHONE:

Dear Dr. _____:

Please evaluate this SoonerCare Member for comprehensive orthodontic treatment. Per OHCA Rule 317:30-5-700, my patient has met the following requirements:

_____ **MEMBER HAS HAD A CARIES FREE INITIAL VISIT;**

_____ **HAS RECEIVED ALL OPERATIVE TREATMENT, INCLUDING A SIX MONTH HYGIENE REEVALUATION INDICATING NO ADDITIONAL TREATMENTS ARE REQUIRED AND REMAINS CARIES FREE FOR 12 MONTHS; AND**

_____ **IS IN GOOD GINGIVAL HEALTH.**

Member appears to meet medical need rules and is eligible for a consultation. Please verify this patient meets the medically necessary criteria for comprehensive treatment.

THANK YOU FOR SEEING _____, AND I ANTICIPATE HEARING FROM YOU SOON.

BEST REGARDS,

_____ Signature

_____ Date

_____ Requesting Dentist Name Printed

OKLAHOMA
Health Care Authority

Serving Oklahomans
through SoonerCare

Instructions for the Oklahoma Health Care Authority Caries Risk Assessment Form (Age 7+)

Overall assessment of caries risk: Select low risk only when only conditions in the low-risk column are present. Select moderate risk when there are conditions present in a combination of the low-risk and moderate-risk columns, but not in the high-risk column. Select high-risk when one or more conditions exist in the high-risk column.

The clinical judgement of the dentist may justify a change of the patient's risk level (increased or decreased) based on review of this form and other pertinent information. For example, missing teeth may not be regarded as high risk for a follow-up patient or other risk factors not listed may be present. In cases where clinical judgement of the dentist apply, additional narrative justifying your scoring is required.

This assessment cannot address every aspect of a patient's health and is not a replacement for the dentist's inquiry and judgement. Additional or more focused assessment may be appropriate for patients with specific health concerns. Finally, this assessment may be only a starting point for evaluating a patient's health status.

This modified caries risk assessment tool is for the use of SoonerCare dental partners. It was originated by the American Dental Association for its members and is based on the opinion of experts who utilized the most up-to-date scientific information available. OHCA partner dentists are encouraged to complete and upload this information on a weekly basis through the secure provider portal.

OHCA is also interested in your opinion regarding this form. Please contact the OHCA dental unit at 405-522-7401 to share your thoughts.

ADDRESS
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

WEBSITES
okhca.org
mysoonercare.org

PHONE
Admin: 405-522-7300
Helpline: 800-987-7767

Patient Name/Member ID_____ Date_____

Birthday_____ Age_____ Rendering Person's Initials_____

	Low Risk	Moderate Risk	High Risk
Contributing Conditions	**Place an X in the box adjacent to applicable conditions.**		
Fluoride Exposure (through drinking water, supplements, professional applications, toothpaste)	Yes	No	
Sugary Foods or Drinks (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups)	Primarily at mealtimes	1-2 between meal exposures/day	3 or more between meal exposures/day
Caries Experience of Mother, Caregiver and/or other Siblings (for patients ages 7-14)	No carious lesions in last 24 months	Carious lesions in last 7-23 months	Carious lesions in last 6 months
Dental Home: established patient of record in a dental office	Yes	No	
General Health Conditions	**Place an X in the box adjacent to applicable conditions.**		
Special Health Care Needs (developmental, physical, medical or mental disabilities that prevent or limit performance of adequate oral health care by themselves or caregivers)	No	Yes (over age 14)	Yes
Chemo/Radiation Therapy	No		Yes
Eating Disorders, Medications that Reduce Salivary Flow, Drug/Alcohol Abuse	No	Yes	
Clinical Conditions	**Place an X in the box adjacent to applicable conditions.**		
Cavitated or Non-Cavitated (incipient) **Carious Lesions or Restorations** (visually or radiographically evident)	No new carious lesions or restorations in last 24 months	1 or 2 new carious lesions or restorations in last 36 months	3 or more carious lesions or restorations in last 36 months
Teeth Missing Due to Caries in past 36 months	No		Yes
Visible Plaque	No	Yes	Yes
Unusual Tooth Morphology that compromises oral hygiene	No	Yes	
Interproximal Restorations - 1 or more	No	Yes	
Exposed Root Surfaces Present	No	Yes	
Restorations with Overhangs and/or **Open Margins;** Open Contacts with Food Impaction	No	Yes	
Dental/Orthodontic Appliances (fixed or removable)	No	Yes	
Severe Dry Mouth (Xerostomia)	No	Yes	
Overall assessment of dental caries risk	**LOW**	**MODERATE**	**HIGH**

Instructions for Caregiver_____

Provider Signature_____

Parent or Guardian Signature_____