PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

BRITISH COLUMBIA | Ministry of Social Development and Poverty Reduction

ORTHODONTIA REQUEST FORM

Mail: PO Box 65339, Vancouver, BC V5N 5P3 | Telephone: 604 419-2000 | Toll-Free: 1 877 PAC-BLUE | pac.bluecross.ca

All requests for orthodontia coverage/eligibility should be submitted to Pacific Blue Cross. All Service Provider enquiries regarding orthodontia coverage should be directed to Pacific Blue Cross using the phone numbers provided above.

PART 1 — GENERAL INFORMATION

The Ministry will only consider funding orthodontic services where there is severe skeletal dysplasia with jaw misalignment of two (2) or more standard deviations.

Does the patient meet this criteria?

- If no, **do not proceed with records**. The orthodontist should submit a claim for examination only using code 01901 up to maximum amount of $50.
- If yes, submit this completed form with all supporting records/materials (i.e. completed treatment plan, radiographs, medical documentation, etc.) along with a standard claim billing fee item 01901 (records fee) in the amount of $200 to the address provided above. The treatment plan must include: all appliances, anticipated duration of active treatment, retention period, proposed fee, whether surgery is required and if yes, a breakdown of the technical surgery fees.

PART 2 — MEMBER INFORMATION

First name	Last name	Personal health number	Birthdate (mm-dd-yyyy)

Street address	City	Province	Postal code

PART 3 — DESCRIPTION OF ORTHODONTIC PROBLEM

1. Profile
   Maxilla: ☐ straight ☐ protrusive ☐ retrusive
   Mandibular: ☐ straight ☐ protrusive ☐ retrusive

2. Occlusion
   Molar: ☐ left ☐ right
   Cuspid: ☐ left ☐ right

3. Crossbite ☐ Anterior ☐ Unilateral ☐ Osseous ☐ Posterior ☐ Bilateral ☐ Dental

4. Mid-lines
   Upper (mm): _____ to _____
   Lower (mm): _____ to _____

5. Overjet (mm): _____ Overbite (%): _____ Palatal impingement: _____

6. Over crowding
   Upper: ☐ mild ☐ moderate ☐ severe
   Lower: ☐ mild ☐ moderate ☐ severe

7. Are there any significant medical or functional implications? Describe:

PART 4 — PRACTITIONER INFORMATION

First name	Last name	Provider number	Office number

Street address	City	Province	Postal code

Practitioner's signature **X**	Date (mm-dd-yyyy)

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