# STATEMENT OF MEDICAL NECESSITY



(*PLEASE PRINT CLEARLY)*

Please note: Physician to complete for insurance reimbursement processing.

## ORDERING PHYSICIAN INFORMATION

Name: ______________________________ Insurance ID#: __________
Last First Middle initial

Address: ______________________________
Street City State Zip

Contact #: ( ) ( ) Off. Manager: ( )
Phone Fax Name Phone

## PATIENT INFORMATION

Name: ______________________________ Date of service: __________
Last First Middle initial mm/dd/20yy

Address: ______________________________
Street City State Zip

Contact # ( ) ( ) ID#
Phone Fax Health Plan Group

## DOCUMENTATION

RELEVANT PATIENT HISTORY – The patient reported the following:

PHYSICAL FINDINGS – The patient presented with the following signs and or symptoms:

## CONE BEAM COMPUTED TOMOGRAPHY HAS BEEN ORDERED FOR THE FOLLOWING PATIENT TO CONFIRM THE CLINICAL IMPRESSION OF OR RULE OUT ONE OR MORE OF THE FOLLOWING SUSPECTED CONDITIONS (ICD9)

**DISEASES OF THE JAWS**
- ❑170.1 Malignant neoplasm of bone; mandible
- ❑213.0 Benign neoplasm of bone; maxilla
- ❑213.1 Benign neoplasm of bone; mandible
- ❑237.7 Neurofibromatosis, unspecified
- ❑350.1 Trigeminal neuralgia
- ❑526.0 Developmental odontogenic cysts
- ❑526.1 Fissural cysts of jaw
- ❑526.2 Other cysts of jaws
- ❑526.3 Central giant cell granuloma
- 526.4 Osteitis, Osteomyelitis, Periostitis
- ❑526.5 Alveolitis of Jaw
- ❑526.8 Other specified diseases the jaws
- ❑526.81 Exostosis of jaw
- ❑526.89 Fibrous dysplasia of jaws
- ❑526.89 Osteoradionecrosis
- ❑526.89 Unilateral condylar/coronoid hyperplasia
- ❑526.89 Mandibular hypoplasia
- ❑534.60 TMJ disorders, unspecified

**DENTAL - TOOTH**
- ❑520.0 Anodontia
- ❑520.1 Supernumerary teeth
- ❑520.2 Abnormalities of size and form (fusion, gemination)
- ❑520.4 Disturbances of tooth formation (enamel hypoplasia)
- ❑520.5 Hereditary disturbances in tooth structure, (i.e. amelogenesis imperfecta)
- ❑520.6 Disturbances in tooth eruption (i.e. impacted)
- ❑521.4 Pathological resorption
- ❑521.6 Ankylosis
- ❑522.4 Acute apical periodontitis of pulpal origin
- ❑522.5 Periapical abscess without sinus
- ❑522.6 Chronic apical periodontitis
- ❑522.7 Periapical abscess with sinus
- ❑522.8 Radicular cyst
- ❑523.3 Acute periodontitis (i.e. periodontal abscess)
- ❑523.4 Chronic periodontitis (i.e. chronic pericoronitis)

**TMJ JOINT DISORDERS**
- ❑524.60 Unspecified TMJ disorders
- ❑524.61 Adhesions and ankylosis (bony or fibrous)
- ❑524.62 TMJ osteoarthritis
- ❑524.63 Articular disc disorder (reducing or nonreducing)
- ❑524.69 Other specified TMJ disorders

**DENTOFACIAL ANOMALIES**
- ❑524.00 Unspecified major anomaly of jaw size
- ❑524.01 Maxillary hyperplasia
- ❑524.02 Mandibular hyperplasia
- ❑524.03 Maxillary hypoplasia
- ❑524.04 Mandibular hypoplasia
- ❑524.05 Macrogenia
- ❑524.06 Microgenia
- ❑524.09 Other specified major anomaly of jaw size
- ❑524.1 Anomalies of relationship of jaw to cranial base
- ❑524.10 Unspecified anomaly (Prognathism, Retrognathism)
- 524.11 Maxillary asymmetry
- ❑524.12 Other jaw asymmetry
- ❑524.19 Other specified anomaly
- ❑524.2 Anomalies (dental arch relationship)
- ❑524.3 Anomalies of tooth position
- ❑524.33 Alveolar mandibular hypoplasia
- ❑524.4 Malocclusion, unspecified
- ❑524.5 Dentofacial functional abnormalities

**DENTAL ALVEOLAR ANOMALIES**
- ❑524.7 Dental alveolar anomalies
- ❑524.70 Unspecified alveolar anomaly
- ❑524.71 Alveolar maxillary hyperplasia
- ❑524.72 Alveolar mandibular hyperplasia
- ❑524.73 Alveolar maxillary hypoplasia
- ❑524.74 Alveolar mandibular hypoplasia
- ❑524.79 Other specified alveolar anomaly
- ❑525.1 Loss of teeth due to trauma, extraction or periodontal disease
- 525.10 Acquired absence of teeth, unspecified
- ❑525.11 Loss of teeth due to trauma
- ❑525.20 Unspecified atrophy of edentulous alveolar ridge
- ❑525.21 Minimal atrophy of mandible
- ❑525.22 Moderate atrophy of mandible
- ❑525.23 Severe atrophy of mandible
- ❑525.24 Minimal atrophy of maxilla
- ❑525.25 Moderate atrophy of maxilla
- ❑525.26 Severe atrophy of maxilla
- ❑525.3 Retained dental root
- 525.8 Enlargement of alveolar ridge NOS

**CRANIOFACIAL**
- ❑749.2 Cleft palate with cleft lip
- ❑754.0 Hemifacial atrophy or hypertrophy
- ❑755.59 Cleidocranial dysplasia
- ❑756.0 Anomalies of Skull/Face
- ❑759.89 Basal Cell Nevus Syn

**FRACTURE**
- ❑802.31 Mandible Fx; condylar, closed
- ❑802.32 Mandible Fx; subcondylar, closed
- ❑802.35 Mandible Fx; angle, closed
- ❑802.36 Mandible Fx; symphysis, closed
- ❑802.37 Mandible Fx; alveolar, closed
- ❑802.38 Mandible Fx; body, closed
- ❑802.39 Mandible Fx; multiple, closed
- ❑802.4 Maxilla Fx; closed
- ❑802.6 Orbit Fx; closed
- ❑802.8 Facial Fx; alveolus, palate, closed
- ❑873.63 Fractured tooth/teeth
- ❑873.73 Fractured tooth/teeth, complicated

**MISCELLANEOUS**
- ❑733.29 Fibrous dysplasia; monostotic
- ❑733.10 Pathologic fracture, unspecified site
- ❑733.4 Aseptic necrosis of bone
- ❑733.81 Malunion
- ❑714.0 Rheumatoid arthritis
- ❑714.30 Juvenile rheumatoid arthritis
- ❑715.8 Osteoarthritis; other specified sites
- ❑784.0 Headache; Facial pain

**TEMPORAL BONE / SINUS**
- ❑387.2 Otosclerosis, cochlear
- ❑461 Sinusitis, acute
- ❑473.7 Pan-sinusitis, chronic
- ❑473.9 Sinusitis, chronic
- ❑784.2 Mass in nose or sinus

Other:

# STATEMENT OF MEDICAL NECESSITY



(*PLEASE PRINT CLEARLY)*

**MAXILLOFACIAL CONE BEAM COMPUTED TOMOGRAPHY (CPT: 70486) AND THREE DIMENSIONAL (3D) REFORMATTING OF THE AXIAL DATA (CPT: 76377) IS THE OPTIMUM IMAGING MODALITY IN THIS CASE BECAUSE IT:**

- ☐ Provides accurate assessment of location, size shape, extent of involvement of pathology affecting the maxillofacial structures.
- ☐ Clearly identifies all pertinent bony anatomic structures (e.g. inferior alveolar canal, maxillary sinus) in three dimensions prior to surgery, minimizing untoward sequelae.
- ☐ Can confirm or rule out the presence of pathology or a condition accounting or contributing to the clinical diagnostic impression.

Other: ____________________________________________

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**Physician Certification:** I certify the medical necessity of the above item(s) for this patient. I have personally completed this form, or directly supervised the completion of this form by my employees. The foregoing information is true, accurate, and complete, to the best of my knowledge.

Physician Signature:______________________________ Date: ______/______/ 20____