Clinical Information for Treatment of Temporomandibular Joint Dysfunction

PART A: Patient/Provider Information – Please Print

Patient Name (Last, First, MI)	Sponsor SSN	Date of Birth (mm/dd/yyyy)

Requesting Provider	Provider Fax #

PART B: Clinical Information – Please check appropriate boxes and make comments as indicated – Please Print

History:
Date of initial symptoms: ____________ (mm/dd/yyyy) Initial date of current episode: ____________ (mm/dd/yyyy)

Recent jaw or facial injury: ☐ Yes ☐ No If yes, date of injury: ____________ (mm/dd/yyyy)

Jaw locking: ☐ Yes ☐ No Bruxism: ☐ Yes ☐ No

Pain when opening jaw: ☐ Yes ☐ No Documented arthritis: ☐ Yes ☐ No

Imaging:
Panorex: ☐ Yes ☐ No Tomogram: ☐ Yes ☐ No MRI: ☐ Yes ☐ No

Treatment(s) to date (please specify): ____
____
____

Clinical Examination:
Muscle or joint pain on palpation: ☐ Yes ☐ No TMJ noise: ☐ Yes ☐ No

Incisal opening limited: ☐ Yes ☐ No Malocclusion: ☐ Yes ☐ No

Jaw deviation: ☐ Yes ☐ No Please indicate: ☐ Left (______ mm deviation) ☐ Right (_______ mm deviation)

Additional comments: ____
____

PART C: Treatment Plan

Service(s) requested: ____
____

PART D: Codes

CDT, CPT, and/or HCPCS codes: ____

Please fax this completed form with supporting clinical documentation and/or other relevant data to:

TriWest Healthcare Alliance – Fax: 866-269-5892

TRICARE Prime Remote, TRICARE Reserve Select – Fax: 866-312-5831

This data will be used in making a final determination.

Note: HIPAA authorization requirements do not apply to protected information used for treatment, payment, or health care operations including medical records requested for the provision of health care services.
Privacy Act Statement: This information is protected under the Privacy Act of 1974 and shall be handled as "for official use only." Violations of this may be punishable by fines, imprisonment, or both.