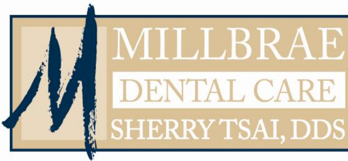

Fax to: 650-475-0596

Mandibular Orthopedic Referral Form / Medical Necessity Form For Medically Diagnosed TMD

Requesting physician's Name:______________________________ Organization:______________________

Phone:_________________________ Fax:___________________________

Patient's Name:______________________________ DOB:___________ Phone:______________________

Diagnosis:

__ Cephalgia (head/facial pain related to craniomandibular pain) - ICD 784.0

__ Atypical Face Pain - ICD 350.2

__ Myalgia/Myoitis - ICD 729.1

__ Temporomandibular joint Disorder (TMD) - ICD 524.60-524.69

__ Dislocation of Jaw, closed or open - ICD 830.0-830.1

__ Other ICD:____

Treatment:

__ Mandibular Orthopedic Repositioning Device, each - S8262

__ Other: ____

Statement of Medical Necessity

This above patient had undergone an evaluation for TMD - review of history, signs and symptoms. This evaluation confirmed the diagnosis of TMD. This evaluation also confirmed that an Oral mandibular orthopedic is medically necessary. Oral mandibular orthopedic therapy is used as an alternative to surgery at this time.

Physician's Signature: _______________________________ Date:____________________

Millbrae Dental Care – Neuromuscular Orthotic TMD Therapy
88 Capuchino Dr. Millbrae CA 94030 ~ (O) 650-583-5880 ~ (F) 650-475-0596
www.millbraedental.com ~ info@millbraedental.com