MILLBRAE DENTAL CARE
SHERRY TSAI, DDS

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

Requesting physician's Name:_____ Organization:_____

Phone:_____ Fax:_____

Patient's Name:_____ DOB:_____ Phone:_____

_____

Diagnosis:

__ Temporomandibular joint Disorder (TMD) - ICD 524.60-524.69 / M26.603

__ Other Dx Code:_____

Treatment:

__ Mandibular Orthopedic Repositioning Device, each - 21299/D7880/E1399 / _____

__ Other: _____

_____

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_____

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_____

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:_____

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