Ohio Department of Health
Children with Medical Handicaps Program (BCMH)
Request for Orthodontic Services

Type or Print Legibly

Fax completed form to 614-564-2501

Client's Name (Last Name, First Name)	BCMH Case Number	Birth Date / /
Parent's Name	Address	
Client's Managing Physician		
Orthodontist's Name	Provider Number	
Address	Telephone Number ( )	Fax Number ( )
Office Contract Person	Email Address	

1. Original problem (Narrative Description)

1. Case Analysis and Treatment Plan for Phase ☐ I ☐ II ☐ III

3. Records (Please check all boxes below indicating records included)

Note: Records are not required for children with cleft lip and palate or other major craniofacial anomalies such as Hermifacial Microsomia Ectodermal Dysplasia and the following syndromes: Weavers, Teacher-Collins, Mobius, Pierre Robin, Aperts, Crouzons, Anodontia (missing less than four teeth not including third molars), Ameliogenesis Imperfecta, Goldenhar Syndrome , and Cleidocranial Dystosia.

TO DETERMINE ELIGIBILITY OF CHILDREN WITH OTHER CRANIOFACIAL CONDITIONS:

Required: ☐ Diagnostic Casts (Models) ☐ Radiographs
☐ Cephalograms (Including Tracings) ☐ Photographs
Optional: ☐ Intraoral Photos ☐ Wrist Plate

Signature of Orthodontist

Date