Medical Necessity Form

Periodontal therapy with a controlled chemotherapy agent

BlueCross BlueShield of Kansas*

Patient name _____ ID. number _____

Tooth/teeth invloved _____

Chemotherapy agent used _____

Please check appropriate indications below. Also please include significance of this tooth/teeth such as root anatomy factors, loss of adjacent teeth, etc.

☐ Bleeding on probe ☐ Unstable pocket depths ☐ Severe ginvival inflammation

☐ Furcation involvement ☐ Mobility

_____

_____

Please list previous treatments including maintenance, planing and scaling, surgeries, and prior periodontal therapy with a controlled chemotherapy agent.

Frequency of maintenance

☐ 3 months ☐ 6 months ☐ Yearly ☐ Other Date of last visit _____

Dates of scaling and root planing

Quadrant I _____ Quadrant II _____

Quadrant III _____ Quadrant IV _____

Dates of periodontal surgical therapy

Quadrant I _____ Quadrant II _____

Quadrant III _____ Quadrant IV _____

Prior periodontal therapy with a controlled chemotherapy agent

Quadrant I _____ Quadrant II _____

Quadrant III _____ Quadrant IV _____

Long range treatment plan

Proposed treatment plan for periodontal therapy with a controlled chemotherapy agent (include the number of teeth being treated at each appointment)

Appointment 1 - teeth numbers _____

Appointment 2 - teeth numbers _____

Appointment 3 - teeth numbers _____

Please attach a copy of the perio chart. Also include x-ray(s) if teeth have advanced mobility/disease.