Orthodontic Continuation of Care Form

Orthodontic Continuation of Care Request Form

Date: _____
Patient Name: _____
Member ID: _____
Member DOB: _____
Code(s) Requiring COC: _____
Current Provider Name: _____
Current Provider NPI#: _____
Banding Date: _____
Total Dollars Paid for Case to Date: _____
Remaining Visits: _____
Balance Requested for Remainder of Case: _____
Previous Carrier (if applicable): _____
Previous Provider Name: _____
Previous Provider Phone #: _____
Previous Provider Address: _____

Procedure:

Complete this form and submit, along with required clinical documentation outlined in THE Molina Dental Services Provider Manual Continuation of Care section, as a prior authorization for code D8999 and all applicable orthodontic codes.

The case will be reviewed by Molina Healthcare and an approved reimbursement amount will be determined

Required Documentation:

- This form and a Completed 2012 ADA Dental Claim Form listing
- D8999 and all applicable orthodontic codes.
- Narrative that includes reason for leaving previous treating Provider, previous Provider contact information, additional treatment needed, and the approximate amount of additional time needed for treatment.