PASSPORT
BY MOLINA HEALTHCARE

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 Provider Manual Continuation of Care section, as a prior authorization for code D8999 and all applicable orthodontic codes. • All documentation should be submitted to:

  Passport by Molina Healthcare Authorizations
  P.O. Box 306
  Milwaukee, WI 53201

- The case will be reviewed by Molina Healthcare and approved or denied for the continuation of care. If approved, an approved reimbursement amount will be determined as well.

Required Documentation:

- This form completed.
- Completed 2012 or greater ADA Dental Claim Form listing D8999 and all applicable orthodontic codes.
- Medical necessity 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.