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.