Orthodontic Discontinuation of Care and/or Transition of Financial Liability Form

Date: _____

Patient Name: _____

Member ID: _____

Member DOB: _____

Provider Name: _____

Provider NPI#: _____

Provider Address: _____

Banding Date: _____

Total Monies Paid for Case to Date: _____

Expected Number of Remaining Visits:_____

List all previously billed orthodontic CDT codes: _____

Procedure:

Complete this form and submit, along with required clinical documentation outlined below, for all applicable CDT orthodontic codes.

The case will be reviewed by the Molina Healthcare Dental Director and a determination will be made. If monies need to be recouped, the provider will be notified of the amount and method of submission. If a member loses Medicaid coverage, the treating orthodontist must return any fees reimbursed by the Managed Care Organization (MCO) for a completed case to the MCO. The Treating orthodontist may bill the member/parent/guardian directly for all services provided after the termination date or another payer if coverage is obtained.

Required Documentation:

- Provider's discontinuation of treatment consent form signed by member or guardian.
- 6-8 Intraoroal/Extraoral photos if available
- Narrative that includes reason for discontinuing treatment.