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