DentaQuest

Orthodontic Continuation of Care Submission Form and Instructions

Date: _____

Member Information (Required)

Name (First & Last)	Date of Birth:	SS or ID#
Address:	City, State, Zip	Area code & Phone number:
Group Name:	Plan Type:	

Provider Information (Required)

Dentist Name:	Provider NPI #	Location ID #
Address:	City, State, Zip	Area code & Phone number:

*** Indicates an optional field**

***Date of Original Approval:**

***Banding Date:d** ***Case Rate Approved on Original PAR:**

***Amount Received by Provider for Original Approved Orthodontic Case:**

The following supporting documentation, while not mandatory, will help to expedite the approval process:

If the member is transferring from an existing Medicaid program:

- **A copy of the original orthodontic approval.**
- **All of the documentation as required for the original provider.**
- **The reason the client left the previous provider.**
- **An explanation of the treatment status.**
- **A complete treatment plan addressing all procedures for which authorization is being requested.**
  - **Total Percent of Orthodontic treatment remaining**
  - **Total Number of months of active orthodontic treatment remaining**
  - **Total number of teeth re-band/bond**
  - **Total Charges for completion of treatment including retention.**

If the member is private pay or transferring from a commercial insurance program:

- **Original diagnostic photos or models (or OrthoCad equivalent) radiographs.**
- **Provider name and contact information.**

Exceptions: The prior authorization requests for clients who initiate orthodontic services before becoming eligible for Medicaid do not require the Colorado Orthodontic Criteria Index Form. However, a complete plan of treatment is required.

Note: If Medicaid clients initiate orthodontic services outside of Medicaid, because they do not meet the requirement of having a handicapping malocclusion, they are not eligible to have their orthodontic services transferred to or reimbursed by Medicaid.

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