CareFirst
Family of health care plans

Continuation of Care Form for Orthodontic Treatment

INSTRUCTIONS

This Continuation of Care Form is to be used for Affordable Care Act (ACA) members who have enrolled in the plan after starting orthodontic treatment or ACA members who have transferred from another orthodontic practice.

Requests for comprehensive orthodontic services for members covered under ACA plan policies require a pre-treatment estimate (PTE) and approval. To determine if orthodontic continuation of care will be approved, the following supporting documentation must be provided:

- Current ADA claim form with current dental terminology (CDT) code for service requested and dentist's charge
- Dated, digital images of original diagnostic study models with frontal and profile views (2) with teeth in full occlusion, plus images from occlusal view of full upper and lower arches separately
- Original dated cephalometric film with measurements and analysis
- Original dated panoramic film
- Clinical summary with diagnosis
- Treatment plan including anticipated duration of active treatment
- Appropriate dated state mandated handicapping labio-lingual deviation (HLD) or Salzmann Evaluation assessment form completed and signed by the orthodontist
- If the member is transferring from another ACA plan or a government funded program (Medicaid), a copy of the original state mandated HLD or Salzmann Evaluation assessment form and the agency's orthodontic approval

Submit completed form to: Mail Administrator, P.O. Box 14115, Lexington, KY 40512-4115 or electronically using payer ID 00580.

Date:

PATIENT INFORMATION

Name (Last, First)		
Date of Birth (mm/dd/yyyy) / /	Member ID Number	
Address	City and State	Zip Code

DENTIST'S INFORMATION (PROVIDING CONTINUATION OF CARE)

Dentist Name	Tax ID Number	Telephone

Address	City and State	Zip Code

ORIGINAL TREATMENT INFORMATION

Dentist Name	Telephone
Address	City, State, Zip Code
Other Carrier (if applicable)	Telephone
Address	City, State, Zip Code

Approval Date (if applicable)	Banding Date	No. of Treatment Months	Total Amount Paid

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