

**NORTH CAROLINA MEDICAID PROGRAM  
ORTHODONTIC TREATMENT TERMINATION REQUEST**

Date: \_\_\_\_\_

Return this letter to:

EDS Prior Approval Unit  
Attn: Orthodontic Review Board  
P.O. Box 31188  
Raleigh, NC 27622

Recipient name: \_\_\_\_\_

Medicaid ID #: \_\_\_\_\_

Months in treatment = \_\_\_\_\_

Estimated months needed to complete treatment = \_\_\_\_\_

Date of termination = \_\_\_\_\_

Reason for termination (check box and attach any supporting documentation):

- recipient moved out of state
- recipient transferred to another provider (specify) \_\_\_\_\_
- recipient death
- recipient non-compliance
- other (specify) \_\_\_\_\_

Retainers delivered (please circle):      Upper    yes    or    no              Lower    yes    or    no

Date retainers delivered: \_\_\_\_\_

Number of paid maintenance visits: \_\_\_\_\_

**If the recipient was only banded, Medicaid may require that a percentage of the banding fee be refunded to the program. Medicaid will contact the provider to make arrangements for the refund.**

Provider number: \_\_\_\_\_

Provider name: \_\_\_\_\_

Provider address: \_\_\_\_\_

\_\_\_\_\_

Provider phone: \_\_\_\_\_