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## **1.0 Description of Services**

Orthodontics is defined as a corrective procedure for functionally handicapping conditions. Such services shall maintain a high standard of quality and shall be within the reasonable limits of those that are customarily available and provided to most persons in the community with the limitations and exclusions hereinafter specified. **Only the procedure codes listed in this policy are covered under the N.C. Medicaid Dental Program.**

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## **2.0 Eligible Recipients**

### **2.1 General Provisions**

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for dental services as described in this policy.

### **2.2 Limitations**

For pregnant Medicaid-eligible recipients with a pink Medicaid identification card, dental services as described in this policy are covered through the day of delivery. Recipients with a blue Medicaid identification card with the program class 'MAFD' and the following statement **"FAMILY PLANNING WAIVER: RECIPIENT ELIGIBLE FOR LIMITED FAMILY PLANNING SERVICES ONLY"** are not eligible for dental services as described in this policy. Refer to **Section 5.3, Procedure Codes and Limitations** for eligibility limitations for individual procedure codes.

### **2.3 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination\*\* (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

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Applicable FARS/DFARS apply.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**\*\*EPSDT and Prior Approval Requirements**

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the Basic Medicaid Billing Guide, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

*Basic Medicaid Billing Guide:* <http://www.ncdhhs.gov/dma/medbillcaguide.htm>

**EPSDT provider page:** <http://www.ncdhhs.gov/dma/EPSDTprovider.htm>

### **3.0 When Services are Covered**

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

#### **3.1 General Criteria**

Medicaid covers dental services when the services are medically necessary and

- a. the procedure is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs,
- b. the procedure can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide, and
- c. the procedure is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

### 3.2 Specific Criteria

The following criteria for functionally handicapping conditions apply when cases are reviewed for N.C. Medicaid orthodontic approval. The probability for approval is increased when two or more of the following criteria exist:

- a. Severe skeletal condition (recipient's age and the direction of growth are also considered).
- b. Occlusion (severe anterior/posterior, transverse, and vertical discrepancies, crossbites with functional shifts).
- c. Crowding must be moderate to severe and functionally intolerable over a long period of time (e.g., occlusal disharmony and/or gingival stripping secondary to severe crowding).
- d. Overbite must be deep, complete, and traumatic.
- e. Overjet (excessive protrusion 6+ mm).
- f. Openbite (excessive 4 to 5mm).
- g. Psychological and emotional factors (e.g., psychosocial inhibition to the normal pursuits of life).
- h. Potential that all problems will worsen.

## 4.0 When Services are Not Covered

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care** services to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

### 4.1 General Criteria

Dental services are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**,
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**,
- c. the procedure duplicates another provider's procedure,
- d. the procedure is experimental, investigational, or part of a clinical trial, or
- e. the criteria specified in this policy have not been met.

#### 4.2 Specific Criteria

Orthodontic services are not covered when the above medical criteria are not met. Additionally, the following types of cases are not eligible for approval:

- a. Early treatment cases in the mixed dentition.
- b. Minor tooth movement cases requiring a relatively short treatment period (i.e., less than twelve months).
- c. Cuspid impactions with a poor prognosis of being brought down into occlusion in the presence of no other significant problems.
- d. Bilateral or unilateral posterior crossbites of moderate severity without a significant mandibular shift or history of temporomandibular dysfunction and a lack of other significant problems.
- e. Class I malocclusions with moderate crowding, no crossbites, overbite and overjet within normal limits.
- f. Simple space closure of mild to moderate anterior spacing.
- g. Simple one arch treatment.
- h. Localized tooth alignment problems requiring a relatively short period of treatment (e.g., simple anterior or posterior crossbites, diastema closure, rotations, etc.).
- i. Cases begun prior to the patient becoming eligible for Medicaid

Interceptive orthodontics is not covered by N.C. Medicaid. All functional treatments involving fixed or removable appliances (e.g., arch expanders, retainers, etc.) are not covered.

#### 5.0 Requirements for and Limitations on Coverage

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care** services to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

Only dental materials accepted by the ADA Council on Dental Therapeutics are accepted for use in the dental care of Medicaid recipients. Specific use of these materials must follow the ADA Council on Dental Therapeutics guidelines.

### 5.1 Prior Approval for Orthodontics Services

Orthodontic services require prior approval. The orthodontic records must be obtained for each case and screened to determine that the case is functionally handicapping. All radiographs, models, and other parts of the orthodontic records must be of acceptable diagnostic quality or the case will be returned.

Refer to **Attachment A – Orthodontic Billing Guide**, for additional information.

### 5.2 Procedure Codes and Limitations for Orthodontics

By State legislative authority, DMA applies service limitations to ADA procedure codes as they relate to individual recipients. These service limitations are applied without modification of the ADA procedure description. Limitations that apply to an entire category of service are described at the beginning of the appropriate subsection. Limitations that apply to an individual procedure code are indicated by an asterisk (\*) beneath the description of that code. Claims for services that fall outside these limitations will be denied unless special approval is granted for services deemed medically necessary for a Medicaid recipient under age 21. Refer to **Section 5.6, Request for Special Approval of a Non-Covered Service or Service Outside the Policy Limitations**.

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### 5.2.1 Comprehensive Orthodontic Treatment

- \* Medicaid approval for fixed treatment also includes functional treatments involving fixed or removable appliances (e.g., arch expanders, retainers, etc.).
- \* Habit appliances are not covered by Medicaid.
- \* Occlusal guards/splints (including TMJ splints) are not covered by Medicaid.

Code	Description	PA Needed?
D8080	Comprehensive orthodontic treatment of the adolescent dentition * limited to recipients under age 21 * use for banding * limited to functionally handicapping malocclusions * once in a lifetime service	Yes
D8670	Periodic orthodontic treatment visit (as part of contract) * limited to recipients under age 21 * use for monthly maintenance visit * limited to functionally handicapping malocclusions * allowed once per calendar month * limited to 23 visits * if the case is approved and the banding is paid, Medicaid will continue to pay for monthly maintenance visits regardless of eligibility * once a case is approved, it is anticipated that all banding and monthly maintenance visits will be completed by the recipient's 21 <sup>st</sup> birthday	Yes
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)) * limited to recipients under age 21 * once in a lifetime service * <b>only use for final claim when orthodontic treatment is complete and less than 23 maintenance visits were paid</b> * requires a post treatment summary * retainers are not covered as a separate procedure	Yes

If a case is approved for fixed appliance treatment, the recipient must **not** be billed for functional treatment or for appliances necessary to complete the approved treatment.

### 5.3 Orthodontic Review Board

The Orthodontic Review Board will determine on a case-by-case basis whether or not to authorize coverage. If necessary, members of the review board will physically examine the recipient before approval of the case. In reaching a decision, the functional need will be examined as well as other factors such as:

- a. The recipient's attitude and ability to meet appointments.
- b. The recipient's ability to follow instructions and cooperate through a lengthy treatment period.
- c. The recipient's ability to maintain an acceptable level of oral hygiene vital to the success of treatment.

#### 5.4 Orthodontic Records

It is essential that Medicaid eligibility be confirmed on the date of the orthodontic records. **If the recipient is not eligible, no payment will be made.**

Medicaid does not cover interceptive orthodontics. Therefore, professional judgment should be used to determine at what stage orthodontic records are taken. Orthodontic records are a once in a lifetime service. Orthodontic records are to be filed together on one two-part 2006 ADA form.

Procedure Code	Description
D0150	Comprehensive oral evaluation
D0330	Panoramic film
D0340	Cephalometric film
D0470	Diagnostic casts

Refer to **Attachment A – Orthodontic Billing Guide**, for additional information and an example of a claim for orthodontic records.

#### 5.5 Notifications to the Provider

Once a decision is made regarding the request for orthodontic services, written notification will be sent to the provider. No additional notification will be made to the provider regarding the claim for the orthodontic records. It will be forwarded for payment processing by EDS.

- a. If the case is approved, EDS will return the prior approval request stamped “Approved” as well as all the orthodontic records.
- b. If the case is denied, EDS will return the denied prior approval form and all orthodontic records. A letter of notification of denial, along with appeal rights, will be mailed to the recipient. A copy of the denial letter will also be mailed to the provider.

**5.6 Request for Special Approval of a Non-Covered Service or Service Outside the Policy Limitations**

Dental providers may request special approval for a service that is non-covered by the NC Medicaid program or falls outside the limitations stated in this policy, if that service is deemed medically necessary for a Medicaid recipient under age 21. All such requests must be submitted in writing prior to delivery of the service. The request must include

- a. a completed two-part 2006 ADA claim form,
- b. any materials needed to document medical necessity (e.g., radiographs, photographs, a letter from the recipient's medical care provider), and
- c. the completed Non-Covered State Medicaid Plan Services Request Form (for recipients under 21 years of age) or a cover letter that documents how the service will correct or ameliorate a defect, physical or mental illness, or a condition [health problem].

This includes documentation about how the service, product, or procedure will correct or ameliorate (improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems) as well as the effectiveness and safety of the service, product, or procedure.

Requests should be mailed to

**Assistant Director  
Clinical Policy and Programs  
Division of Medical Assistance  
2501 Mail Service Center  
Raleigh, NC 27699-2501  
FAX: 919-715-7679**

If the procedure(s) receives special approval and the recipient is Medicaid-eligible on the date the service is rendered, the dentist then can file for reimbursement.

**Note:** A copy of the Non-Covered State Medicaid Plan Services Request Form (for recipients under 21 years of age) can be found on the EPSDT provider page. The Web address is specified below.

**EPSDT provider page:** <http://www.ncdhhs.gov/dma/EPSDTprovider.htm>

## 6.0 Providers Eligible to Bill for the Service

All providers participating in the Medicaid program must provide services in accordance with the rules and regulations of the Medicaid program. Conditions of participation are available with provider enrollment.

## 7.0 Additional Requirements

### 7.1 Orthodontic Transfer Cases

In-state and out-of-state transfers will be reviewed on a case-by-case basis. Transfer cases are approved for **continuation** only.

#### 7.1.1 In-State Transfer Cases

The following information is required for approval of in-state transfer cases:

- a. A completed two-part 2006 ADA form indicating the number of remaining periodic maintenance visits.
- b. A cover letter indicating that the case is an “in-state transfer.” The letter must include:
  - \* the initial provider’s name and address
  - \* the recipient’s history status
  - \* the anticipated length of the remaining treatment

The cover letter and form should be sent to the EDS Prior Approval Unit, Orthodontic Review Board.

**Note:** Providers are reminded that reimbursement for transfer cases is limited to the remaining number of periodic maintenance visits for that recipient.

#### 7.1.2 Out-of-State Transfer Cases

The recipient must be a Medicaid recipient in their previous state of residence to be considered for continuation of treatment.

The following information is required for approval of out-of-state transfer cases:

- a. A completed two-part 2006 ADA form indicating the number of remaining periodic maintenance visits.
- b. Orthodontic records indicating that the case is an “out-of-state transfer.” The records must include a narrative which includes:
  - \* the initial provider’s name and address
  - \* the recipient’s history status
  - \* the anticipated length of the remaining treatment

**Note:** Photos and models are helpful but not necessary. The records and form should be sent to the EDS Prior Approval Unit, Orthodontic Review Board.

**Note:** Providers are reminded that reimbursement for transfer cases is limited to the remaining number of periodic maintenance visits for that recipient.

## 7.2 Terminated Orthodontic Treatment

Case termination prior to completion of treatment should rarely take place. All efforts should be made to complete the active phase of treatment. If the recipient does not have a telephone, they may wish to give the dentist a telephone number of someone to contact, such as a county social worker, friend, or relative.

If circumstances occur beyond control of the dentist (e.g., recipient death or moving out of state) that prevent orthodontic treatment completion, the provider should notify EDS. The provider must submit a written treatment termination form and include supporting documentation, such as when and how attempted contacts were made (i.e., information indicating telephone calls made, messages left with neighbors or friends, letters, etc.).

If the recipient was only banded, Medicaid may require that a percentage of the banding fee be refunded to the program. This will be based on individual case consideration and the circumstances surrounding case termination. In these cases, Medicaid will contact the provider to make arrangements for the refund.

Refer to **Attachment A – Orthodontic Billing Guide**, for additional information and an example of the Orthodontic Treatment Termination Form.

## 8.0 Billing Guidelines

### 8.1 Banding

The prior approval request for the banding (procedure code D8080) will be stamped “Approved” and will indicate the date of approval. It is essential that Medicaid eligibility be confirmed on the date of banding. **If the recipient is not eligible, no payment will be made.**

Refer to **Attachment A – Orthodontic Billing Guide**, for additional information and an example of a claim for orthodontic banding.

### 8.2 Periodic Maintenance Visits

It is anticipated that the treatment period will be completed in 24 to 36 months after initial banding. Periodic maintenance visits are paid only once per calendar month with a total of 23 visits allowed.

Refer to **Attachment A – Orthodontic Billing Guide**, for additional information and an example of a claim for periodic maintenance visit.

### 8.3 Reimbursement of Orthodontic Maintenance Visits During Ineligible Periods

It is essential that Medicaid eligibility be confirmed on the date of banding. Orthodontic periodic maintenance visits will be reimbursed regardless of the recipient’s eligibility status at that visit **as long as the recipient was eligible on the date of banding.** The case must be approved before the initial banding takes place. Banding must occur before maintenance visits are billed.

No other services will be covered during ineligible periods. Providers should make the recipient aware that Medicaid will not pay for any routine or restorative care needed during orthodontic treatment if rendered during ineligible periods.

**8.4 Orthodontic Treatment Extension Request (when paid maintenance visits have not exceeded the 23 allowed)**

It is anticipated that the orthodontic treatment will be completed within 36 months. When the orthodontic treatment period exceeds this 3-year period and the provider has not received payment for the 23 maintenance visits, the provider must submit a written treatment extension request.

Refer to **Attachment A – Orthodontic Billing Guide**, for additional information and an example of the Orthodontic Treatment Extension Request.

**8.5 Orthodontic Case Completion**

Providers are allowed payment for the banding and 23 monthly maintenance visits. Payment received for banding constitutes about one-third of the maximum allowed for the entire treatment. The balance is paid incrementally with each periodic maintenance visit.

In rare instances, it may take fewer than 23 visits to complete treatment. In such cases, a provider may submit a final claim for payment of the balance of remaining visits. Complete the 2006 ADA claim form for procedure code D8680 (orthodontic retention). EDS will manually price the claim, based on the number of remaining visits.

If fewer than 12 maintenance visits were paid, record review is required to substantiate the final claim payment. If it is determined that treatment was not “completed” but rather “terminated,” the final payment will not be allowed.

At case completion, submit a final claim and a written post-treatment summary, which includes the results of the treatment and assessment of the recipient’s cooperation. It is important that Medicaid receives a post-treatment summary in order to complete case records. The final orthodontic claim will not be paid unless a post-treatment summary is also submitted.

Refer to **Attachment A – Orthodontic Billing Guide**, for additional information and a copy of the Orthodontic Post Treatment Summary.

## 9.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 2002

### Revision Information:

Date	Section Revised	Change
10/1/2003	All Sections	Implementation of CDT-4 Procedure Codes and style/grammar revisions
10/1/2004	All Sections	Implementation of the 2002 ADA Claim Form
9/1/2005	Section 2.3, 5.2, and 5.7	A special provision related to EPSDT was added.
12/1/05	Section 2.3	The web address for DMA's EDPST policy instructions was added to this section.
12/1/06	Section 2.3	The special provision related to EPSDT was revised.
12/1/06	Sections 3.0, 4.0, and 5.0	A note regarding EPSDT was added to these sections.
5/1/2007	Sections 2.3, 3.0, 4.0, and 5.0	EPSDT information was revised to clarify exceptions to policy limitations for recipients under age 21 years of age.
06/01/2007	Section 5.6	Revised to include the Non-Covered State Medicaid Plan Services Request Form (for recipients under 21 years of age).
06/01/2007	Section 1.0, 5.2 and Attachment A (Orthodontic Billing Guide).	Updated CDT 2006 Copyright disclaimer and revised the Orthodontic Billing Guide to include the 2006 ADA claim form.

## Attachment A: Orthodontic Billing Guide

### A1: Instructions for Requesting Orthodontic Prior Approval

#### Requests for Orthodontic Prior Approval

Once a case has been screened, the orthodontic records obtained, and it is certain the case is **functionally handicapping**, the following steps should be taken:

- a. Complete one 2006 two-part ADA form for the orthodontic records (i.e., initial exam, panoramic film, cephalometric film, and diagnostic casts).
- b. Complete another 2006 two-part ADA form, which will serve as your request for prior approval to perform orthodontic procedure codes (banding and maintenance).

Mail both forms with the following:

- a. Properly occluded and trimmed dental models
- b. An interpreted cephalometric film
- c. A panoramic film or full series of intraoral films
- d. Intraoral and facial photographs (optional but not reimbursed by Medicaid)
- e. A written narrative which includes:
  - \* the provider's assessment of the recipient's motivation, ability to cooperate for orthodontic care, and ability to maintain oral hygiene
  - \* the provider's assessment of the recipient's oral condition and the need for treatment
  - \* the provider's assessment of the recipient's history of compliance with previous dental care
  - \* the estimated fee for the orthodontic treatment
  - \* the estimated treatment period
  - \* the proposed treatment plan (e.g., reduce overjet, extract premolars, extract supernumerary teeth, expose impacted teeth, remove cysts, restorations, etc.)
  - \* measures taken to restore decayed teeth and/or the dates restorations were completed

The above information should be sent to

**EDS Prior Approval Unit  
ATTN: Orthodontic Review Board  
PO Box 31188  
Raleigh, NC 27622**

When the records are being prepared, be sure that **all** items are clearly labeled with the provider's name and the recipient's name for proper handling and return. All radiographs, models, and other parts of the orthodontic records must be of acceptable diagnostic quality or the case will be returned.

Do not occlude models. Each arch of the model must be wrapped separately in foam, bubble-plastic or a similar padding, and packed in a sturdy corrugated reusable shipping box. Boxes should be sealed with heavy, reinforced paper tape or strapping tape.

Refer to **Section 5.1, Prior Approval for Orthodontics Services**, for additional information.

**A2: Example of a Completed Orthodontic Prior Approval Request**

ADA Dental Claim Form																																																																																										
<b>HEADER INFORMATION</b>					<b>POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)</b>																																																																																					
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input checked="" type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT/Title XIX					12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code <b>Baker, Frances T.</b>																																																																																					
2. Predetermination/Preauthorization Number					13. Date of Birth (MM/DD/CCYY) <b>05/07/1990</b> 14. Gender <input type="checkbox"/> M <input checked="" type="checkbox"/> F 15. Policyholder/Subscriber ID (SSN or ID#) <b>598694859H</b>																																																																																					
<b>INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION</b>					16. Plan/Group Number																																																																																					
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<b>OTHER COVERAGE</b>					<b>PATIENT INFORMATION</b>																																																																																					
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)					18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other <input type="checkbox"/> 19. Student Status <input type="checkbox"/> YES <input type="checkbox"/> PTS																																																																																					
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)					20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																																																																																					
6. Date of Birth (MM/DD/CCYY)		7. Gender <input type="checkbox"/> M <input type="checkbox"/> F		8. Policyholder/Subscriber ID (SSN or ID#)			21. Date of Birth (MM/DD/CCYY)																																																																																			
9. Plan/Group Number		10. Patient's Relationship to Person Named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other			Patient ID/Account # (Assigned by Dentist)																																																																																					
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code																																																																																										
<b>RECORD OF SERVICES PROVIDED</b>																																																																																										
24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description			31. Fee																																																																																	
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34. (Place an 'X' on each missing tooth)																																																																																										
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<b>AUTHORIZATIONS</b>					<b>ANCILLARY CLAIM/TREATMENT INFORMATION</b>																																																																																					
36. I have been informed of the treatment plan and associated fees. I am responsible for all charges for dental services and materials not covered by my dental benefit plan prohibited by law, or the treating dentist or dental practice has obtained my consent with my plan prohibiting all or a portion of such charges. To the extent permitted, I consent to the care and disclosure of my protected health information to carry out the treatment plan in connection with this claim.					38. Place of Treatment <input checked="" type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other																																																																																					
X. Patient/Guardian signature _____ Date _____					39. Number of Enclosures (00 to 99) Radiograph(s) _____ Oral Image(s) _____ Model(s) _____																																																																																					
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.					40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)																																																																																					
X. Subscriber signature _____ Date _____					41. Date Appliance Placed (MM/DD/CCYY)																																																																																					
<b>BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)</b>					42. Months of Treatment Remaining <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)																																																																																					
48. Name, Address, City, State, Zip Code <b>Dr. John Hancock 567 Any Street City, NC 27777-7777</b>					43. Replacement of Prostheses? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)																																																																																					
49. NPI <b>9999999999</b> 50. License Number _____ 51. SSN or TIN _____					44. Date Prior Placement (MM/DD/CCYY)																																																																																					
52. Phone Number <b>(919) 333 - 0000</b> 52A. Additional Provider ID <b>8992000</b>					45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident																																																																																					
					46. Date of Accident (MM/DD/CCYY) _____ 47. Auto Accident State _____																																																																																					
					<b>TREATING DENTIST AND TREATMENT LOCATION INFORMATION</b>																																																																																					
					53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.																																																																																					
					X <b>John Hancock, DDS</b> <b>04/02/2007</b> Signed (Treating Dentist) Date																																																																																					
					54. NPI <b>9999999999</b> 55. License Number _____																																																																																					
					56A. Provider Specialty Code <b>XXXXXXXXXX</b>																																																																																					
					<b>Dr. John Hancock</b> <b>567 Any Street, City, NC 27777-7777</b>																																																																																					
					57. Phone Number <b>(919) 333-0000</b> 58. Additional Provider ID <b>8992000</b>																																																																																					

### A3: Instructions for Filing an Orthodontic Claim

As of March 1, 2007, NC Medicaid began accepting orthodontic claims on the 2006 ADA claim form. The following instructions are specific to that form.

Paper orthodontic claims **must** be completed in black ink only (do not highlight any portion of the claim) to allow the fiscal agent to image all orthodontic claim forms electronically. Providers wishing to file electronic claims must have an electronic claims submission (ECS) agreement on file. Contact the fiscal agent's ECS Department at 1-800-688-6696 for more information.

The following fields **must be completed as described** to allow proper processing of orthodontic claims on the 2006 ADA claim form.

Field No.	Field Name	Explanation
12	Name	Enter the recipient's full name (Last, First, Middle) as it appears on the Medicaid card.
13	Date of Birth	Enter the recipient's date of birth using eight (8) digits (example: July 1, 2007 = 07012007).
14	Gender	Check the appropriate box: M=male, F=female.
15	Subscriber Identifier	Enter the recipient's 10-digit identification number listed on the Medicaid card.
23	Patient ID/Account #	Enter the recipient's medical record number if used by your office. This is optional but will appear on your Remittance and Status Report (RA), if entered.
24	Procedure Date	Enter the date the procedure was completed using eight (8) digits (example: July 1, 2007 = 07012007).
29	Procedure Code	Enter the five (5) digit dental procedure code rendered. <b>Note:</b> All procedure codes must begin with the letter "D".
30	Description	Enter the description of the procedure.
31	Fee	<b>Enter your usual fee for the procedure, <u>not</u> the established Medicaid fee.</b>
32	Other Fee(s)	If applicable, enter the amount of payment received from third party insurance plan(s). <b>Do not</b> include any payments from Medicare Part B or allowable Medicaid copayments.
33	Total Fee	Enter the total charges for all procedures listed on the claim form. Do not deduct Medicaid copayments or third-party insurance payments listed in field 32. The fiscal agent will calculate the maximum amount payable by taking into account any copayments or third-party payments.
34	Missing Teeth Information	Cross out (X) missing teeth, slash (/) teeth to be extracted, circle impacted teeth, and show space closure with arrows (←, →).
35	Remarks	Enter the billing provider's taxonomy.
38	Place of Treatment	Check the box indicating provider's office or enter "3" as the place of treatment. Orthodontic services are covered only if delivered in a provider's office.

Instructions continued on next page

### A3: Instructions for Filing an Orthodontic Claim, continued

Field No.	Field Name	Explanation
48	Name, Address, City, State, Zip Code	Enter the name, address, city, state and zip code + 4 code of the dentist or practice that is to receive payment.
49	NPI	Enter the <b>billing provider's NPI number</b> of the dentist or practice that is to receive payment. <ul style="list-style-type: none"> <li>• If payment is to be made to a <b>group practice</b>, then enter the <b>group NPI number</b>.</li> <li>• If payment is to be made to an <b>individual dentist</b>, then enter the <b>individual dentist NPI number</b>.</li> </ul>
52	Phone Number	Enter the area code and phone number of the billing dentist or practice.
52A	Additional Provider ID	Enter the Medicaid billing provider number. After NPI implementation, the Medicaid billing provider number is required for <u>prior approval purposes only</u> .
53	Signed (Treating Dentist)	Signature of the provider rendering service. The signature certifies that: "Services for which payment is requested are medically necessary and indicated in the best interest of the recipient's oral health. The provider's signature on Medicaid documents and claims shall be binding and shall certify that all information is accurate and complete."  In order to submit claims without a signature on each claim, a "Provider Certification for Signature on File" form must be submitted to Provider Enrollment at EDS. The form is located at <a href="http://www.ncdhhs.gov/dma/Forms/pc.pdf">http://www.ncdhhs.gov/dma/Forms/pc.pdf</a> .
54	NPI	Enter the <b>attending provider's NPI number</b> for the individual dentist rendering service. This number should correspond to the signature in field 53.
56	Name, Address, City, State, Zip Code	Enter the name, address, city, state, and zip code + 4 code.
56A	Provider Specialty Code	Enter the attending provider's taxonomy.
58	Additional Provider ID	Enter the Medicaid attending provider number for the individual dentist rendering service. After NPI implementation, the Medicaid attending provider number is no longer required.

Claims must be sent to

**EDS**  
**PO Box 300011**  
**Raleigh, NC 27622**

Claim forms may be ordered directly from the ADA.

<http://www.ada.org/ada/prod/catalog/index.asp>

Telephone: 1-800-947-4746

American Dental Association  
Attn: Salable Materials Office  
211 E Chicago Avenue  
Chicago, IL 60611-2678

**A4: Example of a Completed Claim for Orthodontic Records**

**ADA Dental Claim Form**

**HEADER INFORMATION**

1. Type of Transaction (Mark all applicable boxes)  
 Statement of Actual Services     Request for Predetermination/Prauthorization  
 EPSDT/Title XIX

2. Predetermination/Prauthorization Number

**INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION**

3. Company/Plan Name, Address, City, State, Zip Code

**OTHER COVERAGE**

4. Other Dental or Medical Coverage?     No (Skip 5-11)     Yes (Complete 5-11)

5. Name of Policyholder/Subsriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)    7. Gender    8. Policyholder/Subsriber ID (SSN or ID#)  
 M     F

9. Plan/Group Number    10. Patient's Relationship to Person Named in #5  
 Self     Spouse     Dependent     Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

**POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)**

12. Policyholder/Subsriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code  
**Baker, Frances T.**

13. Date of Birth (MM/DD/CCYY)    14. Gender    15. Policyholder/Subsriber ID (SSN or ID#)  
**05/07/1990**     M     F    **598694859H**

16. Plan/Group Number    17. Employer Name

**PATIENT INFORMATION**

18. Relationship to Policyholder/Subsriber in #12 Above    19. Student Status  
 Self     Spouse     Dependent Child     Other     YTS     PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)    22. Gender    23. Patient ID/Account # (Assigned by Dentist)  
 M     F

**RECORD OF SERVICES PROVIDED**

24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
03/14/2007					D015	Comprehensive oral evaluation	50.00
03/14/2007					D0290	Panoramic film	100.00
03/14/2007					D040	Cephalometric film	50.00
03/14/2007					D0270	Diagnostic casts	50.00

**MISSING TEETH INFORMATION**

34. (Place an 'X' on each missing tooth)

Permanent												Primary												32. Other Fee(s)		
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J	33. Total Fee
																										250.00

35. Remarks  
XXXXXXXXXX

**AUTHORIZATION**

36. I have been informed of the treatment plan and associated fees. I am responsible for all charges for dental services and materials not covered by my dental benefit plan. I understand that the use of dental services prohibited by law, or the treating dentist or dental practice has the right to refuse treatment with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to the use and disclosure of my protected health information to carry out payment in connection with this claim.

X \_\_\_\_\_ Date \_\_\_\_\_  
Patient/Guardian signature

37. I hereby authorize and direct payment of the dental benefit otherwise payable to me, directly to the below named dentist or dental entity.

X \_\_\_\_\_ Date \_\_\_\_\_  
Subscriber signature

**ANCILLARY CLAIM/TREATMENT INFORMATION**

38. Place of Treatment  
 Provider's Office     Hospital     ECF     Other

39. Number of Enclosures (00 to 99)  
Radiograph(s)    Oral Image(s)    Models

40. Is Treatment for Orthodontics?  
 No (Skip 41-42)     Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining    43. Replacement of Prosthesis?  
 No     Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from  
 Occupational Illness/Injury     Auto accident     Other accident

46. Date of Accident (MM/DD/CCYY)    47. Auto Accident State

**BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subsriber)**

48. Name, Address, City, State, Zip Code  
**Dr. John Hancock**  
**567 Any Street**  
**City, NC 27777-7777**

49. NPI **9999999999**    50. License Number    51. SSN or TIN

52. Phone Number **(919) 333 - 0000**    52A. Additional Provider ID **8992000**

**TREATING DENTIST AND TREATMENT LOCATION INFORMATION**

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X **John Hancock, DDS**    **03/15/2007**  
Signed (Treating Dentist)    Date

54. NPI **9999999999**    55. License Number

56. Address, City, State, Zip Code    56A. Provider Specialty Code **XXXXXXXXXX**

**Dr. John Hancock**  
**567 Any Street, City, NC 27777-7777**

57. Phone Number **(919) 333-0000**    58. Additional Provider ID **8992000**

© 2006 American Dental Association  
J400 (Same as ADA Dental Claim Form - J401, J402, J403, J404)

To Reorder call 1-800-947-4746  
or go online at www.adacatalog.org

A5: Example of a Completed Claim for Orthodontic Banding

**ADA Dental Claim Form**

**HEADER INFORMATION**

1. Type of Transaction (Mark all applicable boxes)  
 Statement of Actual Services     Request for Predetermination/Preadaptation  
 EPSOT/Title XIX

2. Predetermination/Preadaptation Number

**INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION**

3. Company/Plan Name, Address, City, State, Zip Code

**OTHER COVERAGE**

4. Other Dental or Medical Coverage?     No (Skip 5-11)     Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)    7. Gender    8. Policyholder/Subscriber ID (SSN or ID#)  
 M     F

9. Plan/Group Number    10. Patient's Relationship to Person Named in #5  
 Self     Spouse     Dependent     Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

**POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)**

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code  
**Baker, Frances T.**

13. Date of Birth (MM/DD/CCYY)    14. Gender    15. Policyholder/Subscriber ID (SSN or ID#)  
**05/07/1990**     M     F    **598694859H**

16. Plan/Group Number    17. Employer Name

**PATIENT INFORMATION**

18. Relationship to Policyholder/Subscriber in #12 Above    19. Student Status  
 Self     Spouse     Dependent Child     Other     STS     PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)    22. Gender    23. Patient ID/Account # (Assigned by Dentist)  
 M     F

**RECORD OF SERVICES PROVIDED**

24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
04/22/2007			D80			Orthodontic Banding	3500.00

**MISSING TEETH INFORMATION**

34. (Place an 'X' on each missing tooth)	Permanent												Primary												32. Other Fee(s)		
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H		I	J
																	T	S	R	O	P	O	N	M	L	K	3500.00

35. Remarks  
**XXXXXXXXXX 08/04-09-2007 EDS P.A. - Approved**

**AUTHORIZATION**

36. I have been informed of the treatment plan and associated fees. I am responsible for all charges for dental services and materials not covered by my dental benefit plan, or the treating dental practice has advised me with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to the treatment and disclosure of my protected health information to the dental provider in connection with this claim.

X \_\_\_\_\_ Date \_\_\_\_\_  
 Patient/Guardian signature

37. I hereby authorize and direct payment for the dental benefit to be payable to me, directly to the below named dental or dental entity.

X \_\_\_\_\_ Date \_\_\_\_\_  
 Subscriber signature

**ANGULARY CLAIM/TREATMENT INFORMATION**

38. Place of Treatment  
 Provider's Office     Hospital     ECF     Other

39. Number of Enclosures (00 to 99)  
 Radiograph(s)    Oral Image(s)    Model(s)

40. Is Treatment for Orthodontics?  
 No (Skip 41-42)     Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining    43. Replacement of Prosthesis?  
 No     Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from  
 Occupational Illness/Injury     Auto accident     Other accident

46. Date of Accident (MM/DD/CCYY)    47. Auto Accident State

**BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)**

48. Name, Address, City, State, Zip Code  
**Dr. John Hancock  
 567 Any Street  
 City, NC 27777-7777**

49. NPI    50. License Number    51. SSN or TIN  
**9999999999**       **8992000**

52. Phone Number    53. Additional Provider ID  
**(919) 333 - 0000**    **8992000**

**TREATING DENTIST AND TREATMENT LOCATION INFORMATION**

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X **John Hancock, DDS**    **04/02/2007**  
 Signed (Treating Dentist)    Date

54. NPI    55. License Number  
**9999999999**       **XXXXXXXXXX**

56. Address, City, State, Zip Code    58. Additional Provider ID  
**Dr. John Hancock  
 567 Any Street, City, NC 27777-7777**    **8992000**

57. Phone Number    58. Additional Provider ID  
**(919) 333.0000**    **8992000**

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 J400 (Same as ADA Dental Claim Form - J401, J402, J403, J404)

To Reorder call 1-800-947-4746 or go online at www.adacatalog.org

**A6: Example of a Completed Claim for an Orthodontic Maintenance Visit**

ADA Dental Claim Form																																																																																																															
<b>HEADER INFORMATION</b>																																																																																																															
1. Type of Transaction (Mark all applicable boxes) <input checked="" type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Prauthorization <input type="checkbox"/> EPSDT/Title XIX																																																																																																															
2. Predetermination/Prauthorization Number																																																																																																															
<b>INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION</b>																																																																																																															
3. Company/Plan Name, Address, City, State, Zip Code																																																																																																															
<b>POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)</b>																																																																																																															
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code <b>Baker, Frances T.</b>																																																																																																															
13. Date of Birth (MM/DD/CCYY) <b>05/07/1990</b>				14. Gender <input type="checkbox"/> M <input checked="" type="checkbox"/> F				15. Policyholder/Subscriber ID (SSN or ID#) <b>598694859H</b>																																																																																																							
16. Plan/Group Number						17. Employer Name																																																																																																									
<b>OTHER COVERAGE</b>																																																																																																															
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)																																																																																																															
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)																																																																																																															
6. Date of Birth (MM/DD/CCYY)			7. Gender <input type="checkbox"/> M <input type="checkbox"/> F			8. Policyholder/Subscriber ID (SSN or ID#)						19. Student Status <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other <input type="checkbox"/> PTS																																																																																																			
9. Plan/Group Number			10. Patient's Relationship to Person Named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other						20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																																																																																																						
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code																																																																																																															
21. Date of Birth (MM/DD/CCYY)    Gender    Patient ID/Account # (Assigned by Dentist)																																																																																																															
<b>RECORD OF SERVICES PROVIDED</b>																																																																																																															
24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description						31. Fee																																																																																																			
1 <b>04/28/2007</b>					<b>D8670</b>	<b>Orthodontic maintenance visit</b>						<b>125.00</b>																																																																																																			
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35. Remarks <b>XXXXXXXXXX</b>																																																																																																															
<b>AUTHORIZATIONS</b>																																																																																																															
36. I have been informed of the treatment plan and associated fees. I am responsible for all charges for dental services and materials not covered by my benefit plan. I understand that the treating dentist or dental practice has advised me of any limitations or exclusions in my plan prohibiting all or a portion of such charges. To the extent permitted by law, I hereby consent to the performance and disclosure of my protected health information to carry out the treatment plan in connection with this claim.																																																																																																															
X _____ Date _____ Patient/Guardian signature																																																																																																															
37. I hereby authorize and direct payment of the dental benefit to be otherwise payable to me, directly to the below named dental or dental entity.																																																																																																															
X _____ Date _____ Subscriber signature																																																																																																															
<b>ANCILLARY CLAIM/TREATMENT INFORMATION</b>																																																																																																															
38. Place of Treatment <input checked="" type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other																																																																																																															
39. Number of Enclosures (00 to 99) Radiograph(s)    Oral Image(s) <input type="checkbox"/> <input type="checkbox"/>																																																																																																															
40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)																																																																																																															
41. Date Appliance Placed (MM/DD/CCYY)																																																																																																															
42. Months of Treatment Remaining <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)																																																																																																															
43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)																																																																																																															
44. Date Prior Placement (MM/DD/CCYY)																																																																																																															
45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident																																																																																																															
46. Date of Accident (MM/DD/CCYY)																																																																																																															
47. Auto Accident State																																																																																																															
<b>BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)</b>																																																																																																															
48. Name, Address, City, State, Zip Code <b>Dr. John Hancock 567 Any Street City, NC 27777-7777</b>																																																																																																															
49. NPI <b>9999999999</b> 50. License Number    51. SSN or TIN																																																																																																															
52. Phone Number <b>(919) 333 - 0000</b> 52A. Additional Provider ID <b>8992000</b>																																																																																																															
<b>TREATING DENTIST AND TREATMENT LOCATION INFORMATION</b>																																																																																																															
53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.																																																																																																															
X <b>John Hancock, DDS</b> <b>04/30/2007</b> Signed (Treating Dentist)    Date																																																																																																															
54. NPI <b>9999999999</b> 55. License Number																																																																																																															
56. Address, City, State, Zip Code    56A. Provider Specialty Code <b>XXXXXXXXXX</b>																																																																																																															
<b>Dr. John Hancock 567 Any Street, City, NC 27777-7777</b>																																																																																																															
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© 2006 American Dental Association J400 (Same as ADA Dental Claim Form - J401, J402, J403, J404)																																																																																																															
To Reorder call 1-800-947-4746 or go online at www.adecatalog.org																																																																																																															

### A7: Orthodontic Treatment Termination Form

Supporting documentation must be attached to this form. Refer to **Section 7.2, Terminated Orthodontic Treatment**, for additional information. This form is available on DMA's website at [www.ncdhhs.gov/dma/dental.htm](http://www.ncdhhs.gov/dma/dental.htm).

#### ORTHODONTIC TREATMENT TERMINATION FORM

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

Return this letter to:

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

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

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

Prior approval #: \_\_\_\_\_

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) \_\_\_\_\_

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. The EDS post payment analyst will contact the provider to make arrangements for the refund.

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

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

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

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

## **A8: Orthodontic Treatment Extension Request**

Providers must submit an Orthodontic Treatment Extension Request whenever treatment extends beyond the original 36-month approval period. Claims submitted after the approval authorization expires will deny with EOB 2123 “This case has exceeded the initial 36 months approved. Resubmit with a written extension request. Document reason and anticipated completion date to EDS/Prior Approval Unit”. Until an extension request has been submitted in such cases, Medicaid claims will deny. (See an example of this form on the next page.)

Send the Orthodontic Treatment Extension Request to:

**EDS Prior Approval Unit**  
**ATTN: Orthodontic Review Board**  
**PO Box 31188**  
**Raleigh, NC 27622**

Refer to **Section 8.4, Orthodontic Treatment Extension Request**, for additional information. This form is available on DMA’s website at [www.ncdhhs.gov/dma/dental.htm](http://www.ncdhhs.gov/dma/dental.htm).

**ORTHODONTIC TREATMENT EXTENSION REQUEST**

**Note:** Providers are reminded that reimbursement for extended orthodontic treatment is limited to the remaining number of periodic maintenance visits for that recipient (total of twenty-three visits).

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

Return this letter to:

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

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

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

Prior approval #: \_\_\_\_\_

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

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

Reason for extension: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

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

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

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

**A9: Orthodontic Post Treatment Summary**

Upon case completion, an Orthodontic Post Treatment Summary must be submitted to the address listed below. (See an example of this form on the next page.) If fewer than 12 maintenance visits were paid, attach copies of the recipient's chart notes.

**EDS Prior Approval Unit**  
**ATTN: Orthodontic Review Board**  
**PO Box 31188**  
**Raleigh, NC 27622**

Refer to **Section 8.5, Orthodontic Case Completion**, for additional information. This form is available on DMA's website at [www.ncdhhs.gov/dma/dental.htm](http://www.ncdhhs.gov/dma/dental.htm).

**ORTHODONTIC POST TREATMENT SUMMARY**

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

Return this letter to:

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

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

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

Prior approval #: \_\_\_\_\_

Active phase of treatment has been completed. Date of debanding: \_\_\_\_\_

Results obtained (please circle):      excellent              good              fair              poor

Assessment of recipient cooperation:    excellent              good              fair              poor

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

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

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

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