Continuation of Care Submission Form

Date:_____

Patient Information

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

Provider Information

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

Name of Previous Vendor that issued original approval:

Banding Date: **Case Rate Approved By Previous Vendor:**

Amount Paid for Dates of Service That Occurred Prior to DentaQuest:

Amount Owed for Dates of Service That Occurred Prior to DentaQuest:

Balance Expected for Future Dates of Service:

Remaining services and quantities to be paid from prior approval:

Additional information required:

If approved through a prior Medicaid vendor, please submit the following:

- A completed Orthodontic Continuation of Care form
- A completed 2006 or greater ADA claim form listing the services to be rendered
- A copy of the member's prior approval letter including the total approved case fee and payment structure
- Detailed payment history and records

If approved through a private arrangement or commercial plan also include:

- A copy of the original study models or a complete set of diagnostic photographs prior to the patient being treated
- Panorex film

Mail to:
DentaQuest, LLC
Attn: Continuation
PO Box 2906
Milwaukee, WI 53201-2906