Orthodontic 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: _____

Numbers of adjustments remaining: _____

Additional information required:

- ❑ If the member is transferring from an existing Medicaid program: A copy of the original orthodontic approval.
- ❑ If the member is private pay or transferring from a commercial insurance program: Original diagnostic photos or OrthoCad equivalent, radiographs (optional).

Submit to:
DentaQuest - TennCare
Attn: Pre-authorizations
PO Box 2906
Milwaukee, WI 53201-2906
800.417.7140