DentaQuest

Orthodontic Termination of Care Submission Form

Date:_____

Member Information (Required)

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

Provider Information (Required)

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

Claim Information (Required)

Date of Original Approval:	Original PAR Number:	Procedure Code:
Banding Date:	Case Rate (Amount) Approved on Original PAR:	Last Seen Date:
Provider's estimate of treatment completed (expressed as a percentage):	Reason Given for Termination of Treatment:	

Mail to: DentaQuest-CO Attn: Continuation P.O. BOX 2906 Milwaukee, WI 53201-2906