FORMS

Number	Name	Revision Date
DHHS 126	Confidential Complaint	06/2007
DHHS 130	Claim Adjustment Form 130	03/2007
DHHS 205	Medicaid Refunds	01/2008
DHHS 931	Health Insurance Information Referral Form	02/2018
	Reasonable Effort Documentation	04/2014
	Duplicate Remittance Advice Request Form	09/2017
	SCDHHS HLD Orthodontic Assessment	11/2023
	SCDHHS Orthodontic Continuation of Care	02/2022

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH
AND HUMAN SERVICES

CONFIDENTIAL COMPLAINT

SEND TO: DIRECTOR, DIVISION OF PROGRAM INTEGRITY
DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. BOX 100210, 1801 MAIN STREET, COLUMBIA, SOUTH CAROLINA 29202-3210

PROGRAM INTEGRITY

THIS REPORT IS DESIGNED FOR THE REPORTING OF POSSIBLE ABUSE BY MEDICAID PROVIDERS AND/OR RECIPIENTS. USE THE SPACE BELOW TO EXPLAIN IN DETAIL YOUR COMPLAINT. PLEASE IDENTIFY YOURSELF AND WHERE YOU CAN BE REACHED FOR FUTURE REFERENCES. UNLESS OTHERWISE INDICATED, ALL INFORMATION SHOULD BE PRINTED OR TYPED.

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

SUSPECTED INDIVIDUAL OR INDIVIDUALS:	
NPI or MEDICAID PROVIDER ID: (if applicable)	MEDICAID RECIPIENT ID NUMBER: (if applicable)
ADDRESS OF SUSPECT:	LOCATION OF INCIDENT:
	DATE OF INCIDENT:
COMPLAINT:	

NAME OF PERSON REPORTING: (Please print)	SIGNATURE OF PERSON REPORTING:	DATE OF REPORT

ADDRESS OF PERSON REPORTING:	TELEPHONE NUMBER OF PERSON REPORTING:
	SIGNATURE: (SCDHHS Representative Receiving Report)

South Carolina Department of Health and Human Services - Claim Adjustment Form 130

Provider Name: (Please use black or blue ink when completing form)

Provider Address :

Provider City , State, Zip:

Total paid amount on the original claim:

Original CCN:

Provider ID:

NPI:

Recipient ID:

Adjustment Type:

◯ Void ◯ Void/Replace

Originator:

◯ DHHS ◯ MCCS ◯ Provider ◯ MIVS

Reason For Adjustment: (Fill One Only)

- ◯ Insurance payment different than original claim
- ◯ Keying errors
- ◯ Incorrect recipient billed
- ◯ Voluntary provider refund due to health insurance
- ◯ Voluntary provider refund due to casualty
- ◯ Voluntary provider refund due to Medicare
- ◯ Medicaid paid twice - void only
- ◯ Incorrect provider paid
- ◯ Incorrect dates of service paid
- ◯ Provider filing error
- ◯ Medicare adjusted the claim
- ◯ Other

For Agency Use Only

Analyst ID:

- ◯ Hospital/Office Visit included in Surgical Package
- ◯ Independent lab should be paid for service
- ◯ Assistant surgeon paid as primary surgeon
- ◯ Multiple surgery claims submitted for the same DOS
- ◯ MMIS claims processing error
- ◯ Rate change
- ◯ Web Tool error
- ◯ Reference File error
- ◯ MCCS processing error
- ◯ Claim review by Appeals

Comments:

Signature:_____ Date:_____

Phone:_____

DHHS Form 130 Revision date: 03-13-2007

South Carolina Department of Health and Human Services
Form for Medicaid Refunds

Purpose: This form is to be used for all refund checks made to Medicaid. This form gives the information needed to properly account for the refund. If the form is incomplete, the provider will be contacted for the additional information.

Items 1, 2 or 3, 4, 5, 6, & 7 must be completed. **Attach appropriate document(s) as listed in item 8.**

1. Provider Name: _____

2. Medicaid Legacy Provider # ☐☐☐☐☐☐
(Six Characters)

OR

3. NPI# ☐☐☐☐☐☐☐☐☐☐ **& Taxonomy** ☐☐☐☐☐☐☐☐☐☐

4. Person to Contact: _____ **5. Telephone Number:** _____

6. Reason for Refund: [check appropriate box]

☐ Other Insurance Paid (please complete **a – f** below and attach insurance EOMB)
- **a** Type of Insurance: ( ) Accident/Auto Liability ( ) Health/Hospitalization
- **b** Insurance Company Name _____
- **c** Policy #:_____
- **d** Policyholder: _____
- **e** Group Name/Group: _____
- **f** Amount Insurance Paid:_____

☐ Medicare
- ( ) Full payment made by Medicare
- ( ) Deductible not due
- ( ) Adjustment made by Medicare

☐ Requested by DHHS (please attach a copy of the request)

☐ Other, describe in detail reason for refund:

_____
_____
_____
_____

7. Patient/Service Identification:

Patient Name	Medicaid I.D.# (10 digits)	Date(s) of Service	Amount of Medicaid Payment	Amount of Refund

8. Attachment(s): [Check appropriate box]

☐ Medicaid Remittance Advice (required)

☐ Explanation of Benefits (EOMB) from Insurance Company (if applicable)

☐ Explanation of Benefits (EOMB) from Medicare (if applicable)

☐ Refund check

Make all checks payable to: South Carolina Department of Health and Human Services
Mail to: SC Department of Health and Human Services
Cash Receipts
Post Office Box 8355
Columbia, SC 29202-8355

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM

Provider or Department Name: _____ Provider ID or NPI: _____

Contact Person: _____ Phone #: _____ Date: _____

I ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS

Beneficiary Name: _____ Date Referral Completed: _____

Medicaid ID#: _____ Policy Number: _____

Insurance Company Name: _____ Group Number: _____

Insured's Name: _____ Insured SSN: _____

Employer's Name/Address: _____

II CHANGES TO AN INSURANCE RECORD THAT IS IN THE MMIS – MIVS SHALL WORK WITHIN 5 DAYS

_____ a. beneficiary has never been covered by the policy – close insurance.

_____ b. beneficiary coverage ended - terminate coverage (date) _____

_____ c. subscriber coverage lapsed - terminate coverage (date) _____

_____ d. subscriber changed plans under employer - new carrier is _____

- new policy number is _____

_____ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.

(name) _____

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

Submit this information to Medicaid Insurance Verification Services (MIVS).

Fax:	**or**	**Mail:**
803-252-0870		Post Office Box 101110 Columbia, SC 29211-9804

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REASONABLE EFFORT DOCUMENTATION

PROVIDER _____ DOS _____

NPI or MEDICAID PROVIDER ID _____

MEDICAID BENEFICIARY NAME _____

MEDICAID BENEFICIARY ID# _____

INSURANCE COMPANY NAME _____

POLICYHOLDER _____

POLICY NUMBER _____

ORIGINAL DATE FILED TO INSURANCE COMPANY _____

DATE OF FOLLOW UP ACTIVITY _____

RESULT:

FURTHER ACTION TAKEN:

DATE OF SECOND FOLLOW UP _____

RESULT:

I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAYMENT OR SUFFICIENT RESPONSE FROM THE PRIMARY INSURER.

_____

(SIGNATURE AND DATE)

ATTACH A COPY OF THE FORM TO A NEW CLAIM AND FORWARD TO YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.

Revised 04/2014

South Carolina Department of Health and Human Services
Duplicate Remittance Advice Request Form

Purpose: This form is to be used for all requests for duplicate remittance advices from South Carolina Medicaid. The form must be completed in its entirety in order to honor the request. If the form is incomplete, the form will be returned requesting the additional information.

Please contact the SCDHHS Medicaid Provider Service Center (PSC) at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us for instructions on submission of your request.

1. Provider Name: _____

2. Medicaid Legacy Provider # _____ (Six Characters)

   NPI# _____ Taxonomy _____

3. Person to Contact: _____ Telephone Number: _____

4. Please list the date(s) of the remittance advice for which you are requesting a duplicate copy:

   _____
   _____
   _____
   _____
   _____

   Note: Remittance advices are available electronically through the Web Tool. Please check the Web Tool for the availability of the remittance advice date before submitting your request.

5. Street Address for delivery of request:

   Street: _____
   City: _____
   State: _____
   Zip Code: _____

6. Charges for duplicate remittance advice(s) are as follows:

   Request Processing Fee - $20.00

   Page(s) copied - .20 per page

I understand and acknowledge that a charge is associated with this request and will be deducted from my provider's payment by debit adjustment on a future remittance advice.

_____ _____

Authorizing Signature **Date**

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Submit your Claim Reconsideration request to:

Fax: 1-855-563-7086

or

Mail: South Carolina Healthy Connections Medicaid
ATTN: Claim Reconsiderations
Post Office Box 8809
Columbia, SC 29202-8809

CLAIM RECONSIDERATION FORM

Instructions: Complete this form within 30 days of receipt of the remittance advice reflecting the denied claim, and attach all documentation in support of your request. A separate SCDHHS CR form is required for each claim control number (CCN). Allow up to 60 days for a written response. Claim disputes must first be initiated through the Provider Service Center (PSC). Enter the PSC Communication ID in the required field below. For questions, contact the PSC at 1-888-289-0709. **Note:** Timely filing guidelines apply.

Section 1: Beneficiary Information

Name (Last, First, MI): _____

Date of Birth: _____ Medicaid Beneficiary ID: _____

Section 2: Provider Information

Specify your affiliation: ☐ Physician ☐ Hospital ☐ Other (DME, Lab, Home Health Agency, etc.): _____

NPI: _____ Medicaid Provider ID: _____ Facility/Group/Provider Name: _____

Return Mailing Address: _____
Street or Post Office Box *State* *ZIP*

Contact: _____ Email: _____ Telephone #: _____ Fax #: _____

Section 3: Claim Information *(Only one CCN allowed per request.)*

Communication ID: _____ CCN: _____ Date(s) of Service: _____

Section 4: Claim Reconsideration Information

What area is your denial related to? (Please select below)

- ☐ Ambulance Services
- ☐ Autism Spectrum Disorder (ASD) Services
- ☐ Clinic Services
- ☐ Community Long Term Care (CLTC)
- ☐ Community Mental Health Services
- ☐ Department of Disabilities and Special Needs (DDSN) Waivers
- ☐ Durable Medical Equipment (DME)
- ☐ Early Intervention Services
- ☐ Enhanced Services
- ☐ Federally Qualified Health Center (FQHC)
- ☐ Home Health Services
- ☐ Hospice Services
- ☐ Hospital Services
- ☐ Licensed Independent Practitioner's Rehabilitative Services (LIPS)
- ☐ Local Education Agencies (LEA)
- ☐ Medically Complex Children's (MCC) Waivers
- ☐ Nursing Facility Services / Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
- ☐ Optional State Supplementation (OSS)
- ☐ Pharmacy Services
- ☐ Physicians Laboratories, and Other Medical Professionals Specify: _____
- ☐ Private Rehabilitative Therapy and Audiological Services
- ☐ Psychiatric Hospital Services
- ☐ Rehabilitative Behavioral Health Services (RBHS)
- ☐ Rural Health Clinic (RHC)
- ☐ Targeted Case Management (TCM)
- ☐ Other: _____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Section 5: Desired Outcome

Request submitted by:

Print Name: _____

Signature:_____ Date: _____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Clear Form

HANDICAPPING LABIO-LINGUAL DEVIATION INDEX (HLD) ASSESSMENT

Patient Name: _____ MEDICAID ID: _____ DOB: _____

All necessary dental work completed? Yes ☐ No ☐ Patient oral hygiene: Excellent ☐ Good ☐ Poor ☐
(All dental work must be completed and oral hygiene must be good BEFORE orthodontic treatment is approved.)

PROCEDURE (use this score sheet and a Boley Gauge or disposable ruler):
• Indicate by checkmark next to A or B which criteria you are submitting for review, however, documentation submitted for the case will be applied to both Part A and Part B criteria to ensure accurate determination of medically necessary services.
• Position the patient's teeth in centric occlusion.
• Record all measurements in the order given and round off to the nearest millimeter (mm).
• Enter score "0" if condition is absent.

A. ☐ CONDITIONS 1-7 ARE AUTOMATIC QUALIFIERS (Mark "X" in the box on the right if condition is present)	
1. Documented diagnosis of at least one of the following craniofacial anomalies (circle all that apply and indicate with an "X" if at least one condition was selected): • *Cleft lip or palate* • *Pierre-Robin sequence* • *Hemifacial or craniofacial microsomia* • *Crouzon, Apert, or Treacher-Collins syndrome* • *Condylar aplasia* • *Other (if not listed above, specify the diagnosis of the craniofacial anomaly)* _____	☐
2. Deep impinging overbite with severe soft tissue damage, either of the palate or the mandibular anterior gingival tissue.	☐
3. Crossbite of individual anterior teeth when destruction of the soft tissue is present.	☐
4. Overjet greater than 8 mm or reverse overjet greater than 3.5 mm	☐
5. Severe traumatic deviations	☐
6. Surgical malocclusion with orthognathic surgery	☐
7. Impacted anterior teeth (includes centrals, laterals and cuspids) that will not erupt into the arches without orthodontic or surgical intervention. (Does not include cases where incisors or canines are going to erupt ectopically).	☐
B. ☐ CONDITIONS 8-16 MUST SCORE 25 POINTS OR MORE TO QUALIFY (Enter measurements)	
8. Overjet in mm. **Do *not* record overjet and reverse overjet on the same patient.**	mm ____
9. Reverse overjet of 3.5 mm or less. **Do *not* record overjet and reverse overjet on the same patient.**	____ x 5 = _____
10. Overbite in mm. **Do *not* record overbite and open bite on the same patient.**	mm____
11. Anterior open bite in mm. **Do *not* record overbite and open bite on the same patient.**	____ x 4 = _____

12. Ectopic eruption: Count each tooth, excluding third molars. **If both anterior crowding and ectopic eruptions are present in the anterior portion of the mouth, score only the most severe condition. Do not score both conditions.**	____ x 3 = _____
13. Anterior crowding: Anterior arch length insufficiency must exceed 3.5mm; score one point for maxilla and one point for mandible; 2 points maximum for anterior crowding. The maximum number of points for this item is therefore 10 points (5 upper and 5 lower). **If both anterior crowding and ectopic eruptions are present in the anterior portion of the mouth, score only the most severe condition. Do not score both conditions.**	____ x 5 = _____
14. Impacted posterior teeth (excluding third molars) that will not erupt into the arches without orthodontic or surgical intervention. (Do not report teeth that are going to erupt ectopically)	____ x 2 = _____
15. Labio-lingual Spread: Measure the distance between the most protruded tooth and the normal archline or most lingually displaced adjacent anterior tooth. (Includes Class II Division 2)	____ x 1 = _____
16. Posterior unilateral crossbite: This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may be both palatal or both completely buccal in relation to the mandibular posterior teeth. Report the number of sides with presence of posterior crossbite and multiply by four (4).	_____
TOTAL SCORE (must score 25 points or more to qualify)	0 _____

DENTITION ☐Primary ☐Transitional ☐Adolescent

DOCUMENTATION ATTACHED
(Photos and cephalogram required)

☐ Cephalogram (Required for all cases. Must be original image with embedded scale or notation of image scale.)
☐ Panorex (required for impacted teeth)
☐ Photographs (Required for all cases. High quality facial and intra-oral)
☐ Other (specify)_____

REQUEST
☐ Limited Treatment
☐ Comprehensive treatment
☐ Continued Treatment (for transfer cases)

COMMENTS/NARRATIVE

PROVIDER NAME _____ **PROVIDER NPI**_____

PROVIDER SIGNATURE _____ **DATE**_____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

GUIDELINES AND RULES FOR COMPLETING THE HLD ASSESSMENT FORM

Provider is encouraged to score the case and exclude any case that obviously would *not* qualify for treatment.
Upon completion of the HLD Assessment form, review all measurements and calculations for accuracy.

a. Indicate by checkmark next to A or B which criteria you are submitting for review, however, documentation submitted for the case will be applied to both Part A and Part B criteria to ensure accurate determination of medically necessary services.
b. Position the patient's teeth in centric occlusion.
c. Record all measurements in the order given and round off to the nearest millimeter.
d. Enter the score "O" if condition is absent.

A. CONDITIONS 1 - 7 ARE AUTOMATIC QUALIFIERS

1. Craniofacial Anomalies
   - Cleft lip or palate
   - Pierre-Robin Sequence
   - Hemifacial or Craniofacial Microsomia
   - Crouzon, Apert, or Treacher Collins Syndrome
   - Condylar Aplasia
   - Other (if not listed above, specify the diagnosis of the craniofacial anomaly)

   The anomaly *must* be demonstrated on the study model and/ or intraoral/extraoral photographs; and proper diagnosis by credentialed expert(s) supported by written documentation. Indicate an **"X"** if present.

2. Deep impinging overbite with Severe Soft Tissue Damage – Lower incisors causing severe tissue damage of the palate, such as tissue laceration, ulcerations, or tissue tears (damage must be more than indentations) and/or mandibular anterior gingival trauma, such as clinical attachment loss, must be present and clearly visible in the mouth. Indicate an **"X"** on the score sheet if present. This condition is considered to be a handicapping malocclusion.

3. Crossbite of individual anterior teeth -When clinical attachment loss and recession of the gingival margin are present. Gingival recession *must* be at least 2 mm deeper than the adjacent teeth. In the case of a canine, the amount of gingival recession should be compared to the opposite canine. Indicate an **"X"** on the score sheet when destruction of soft tissue is present. This condition is considered to be a handicapping malocclusion.

4. Overjet greater than 8 mm or reverse overjet greater than 3.5 mm – Overjet is recorded with patent's teeth in centric occlusion and is measured from the labial of the lower incisors to the labial of the corresponding upper central incisors. This measurement should record the greatest distance between any upper central incisors and its corresponding lower central or lateral incisor. If the overjet is greater than 9 mm or mandibular protrusion (reverse overjet) is greater than 3.5 mm, indicate an **"X**" on the score sheet. This condition is considered to be a handicapping malocclusion.

5. Severe traumatic deviations – damage to skeletal and/or soft tissue as a result of trauma or other gross pathology. These might include, for example, loss of a premaxillary segment by burns or accident, the result of osteomyelitis, or other gross pathology. If present, indicate an **"X"** on the score sheet.

6. Surgical malocclusion with orthognathic surgery – Documentation of treatment plan indicating orthognathic surgery or approval for the surgical case must be included with the prior authorization request. Indicate an **"X"** on the score sheet.

7. Impacted Anterior teeth- This includes centrals, laterals and cuspids. Only impacted anterior teeth that will not erupt into the arches without orthodontic or surgical intervention. Impacted anterior teeth not indicated for extraction, but with arch space available for correction are treatment planned to be brought into occlusion. (Does not include cases where incisors or canines are going to erupt ectopically). Indicate an **"X"** on the score sheet with presence of at least one impacted anterior tooth

B. CONDITIONS 8-16 MUST SCORE 25 POINTS OR MORE TO QUALIFY

8. Overjet -this is recorded with the patient's teeth in centric occlusion and is measured from the labial surface of a lower incisor to the labial surface of an upper central incisor. Measure parallel to the occlusal plane. Do not use the upper lateral incisors or cuspids. The measurement may apply to only one (1) tooth if it is severely protrusive. **Do *not* record overjet and mandibular protrusion (reverse overjet) on the same patient**. Measure overjet in millimeters.

9. Mandibular (dental) protrusion or reverse overjet -measured from the labial surface of a lower incisor to the labial surface of an upper central incisor. Do *not* use the upper lateral incisors or cuspids for this measurement. **Do *not* record mandibular protrusion (reverse overjet) and overjet on the same patient**. The measurement in millimeters is entered on the score sheet and multiplied by five (5).

10. Overbite -a pencil mark on the tooth indicating the extent of the overlap assists in making this measurement. Hold the pencil parallel to the occlusal plane when marking and use the incisal edge of one of the upper central incisors. Do *not* use the upper lateral incisors or cuspids. The measurement is done on the lower incisor from the incisal edgeto the pencil mark. "Reverse" overbite may exist and should be measured on an upper central incisor - from the incisal edge to the pencil mark. **Do *not* record overbite and open bite on the same patient.** Measure overbite in millimeters.

11. Open bite -measured from the incisal edge of an upper central incisor to the incisal edgeof a lower incisor. Do *not* use the upper lateral incisors or cuspids for this measurement. **Do *not* record overbite & open bite on the same patient.** The measurement in millimeters is entered on the score sheet and multiplied by four (4).

12. Ectopic eruption -count each tooth excluding third molars. Enter the number of teeth on the score sheet and multiply by three (3). If anterior crowding, is also present with an ectopic eruption in the anterior portion of the mouth, score only the most severe condition (the condition represented by the most points). **DO NOT SCORE BOTH CONDITIONS**.

13. Anterior crowding – Measure each arch separately. Anterior arch length insufficiency *must* exceed 3.5 mm. Mild rotations that may react favorably to stripping or mild expansion procedures are *not* to be scored as crowded. Score one (1) point for a maxillary arch with anterior crowding and multiply by five (5). Score one (1) point for a mandibular arch with anterior crowding and multiply by five (5). Combine the scores and enter on the form. If an ectopic eruption in the anterior portion of the mouth, is also present with anterior crowding score only the most severe condition (the condition represented by the most points). **DO NOT SCORE BOTH CONDITIONS**.

14. Impacted posterior teeth (premolars and molars, excluding third molars). Impacted posterior teeth that will not erupt into the arches without orthodontic or surgical intervention. Impacted posterior teeth not indicated for extraction, but with arch space available for correction are treatment planned to be brought into occlusion. (Do not report teeth that are going to erupt ectopically). Enter number of impacted posterior teeth that fit the criteria above and multiply by two (2).

15. Labio-lingual spread -use a Boley gauge (or disposable ruler) to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to a line representing the normal arch. Otherwise, the total distance between the most protruded tooth and the most lingually displaced adjacent anterior tooth is measured. When multiple anterior crowding of teeth is observed, all deviations should be measured for labio- lingual spread but only the most severe individual measurement should be entered on the on the score sheet. This includes Class II Division 2 cases. Enter the measurement in mm and multiply by one (1).

16. Posterior crossbite -this condition involves two (2) or more adjacent teeth, one (1) of which *must* be a molar. The crossbite *must* be one in which the maxillary posterior teeth involved may be both palatal or completely buccal in relation to the mandibular posterior teeth. Report the number of sides with the presence of posterior crossbite and multiply by four (4).

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

ORTHODONTIC CONTINUATION OF CARE SUBMISSION FORM

Date_____

Patient Information		
Name (First, last): _____	Date of Birth: _____	Medicaid ID: _____
Address: _____	City, State, Zip Code: _____	Phone Number: _____
Continuing Provider Information		
Performing Provider Name (First, Last): _____	Performing Provider NPI _____	
Office/ Business Entity/ Billing Provider Name: _____	Office Business Entity/Billing Provider NPI _____	
Office Location Address: _____	City, State, Zip Code: _____	Phone Number: _____
Original Provider Information		
Provider Name (First, Last): _____	Office Name: _____	Provider NPI: _____
Office Location Address: _____	City, State, Zip Code: _____	Phone Number: _____
Orthodontic Case Information		
State Medicaid authorizing the initial approval: _____	Authorization ID (if applicable): _____	
Banding Date: _____	Length of treatment approved: _____	Approved Case (check one): Comprehensive ☐ Limited ☐

Rev. Dec. 2021