ORTHODONTIC CERTIFICATION

Orthodontic Certification

I have read the Orthodontic Agreement and accept its provisions.

This agreement is being submitted with a prior authorization request for:

_____ _____

Name of Beneficiary | Medicaid ID Number

_____ _____

City or County of Residence | Date of Birth

_____ _____

Date of Dental Screen | Name of Dental Screening Provider (Must be dentist)

Name and address of orthodontic provider:

_____

_____

_____

_____ _____

Signature (Must be orthodontic provider) | Date

_____ _____ _____

Prior Authorization Number | Signature of Orthodontic Consultant | Date

Revised 04/2009