CareSource

Orthodontic Form for Non-Compliance/Termination with Comprehensive or Interceptive Orthodontic Treatment

Member Information

Last Name: _____ First Name: _____

CareSource ID#: _____ Authorization Number: _____

Health Partner's Information

Name: _____ CareSource Health Partner ID #: _____

Address: _____ Phone/Fax number(s): _____

Patient Compliance

Date Banded: _____ Number of months of care completed: _____

Number of Actual Patient Visits since Banding?: _____

Member was not complying with my office policy as noted below:

Deficiencies in compliance as noted above have reached a point that they are likely to interfere with achieving the goals of treatment.

____ I have offered to remove the appliances.
____ I have offered to fabricate retainers for the patient to maintain the treatment that currently exists.

Arrangements have been made to remove the appliances and health partner retainers Yes No

Treating Dentist Signature:	Date:

Recipient's Acknowledgement:

I have decided that I want to discontinue the orthodontic treatment for:
I understand that the treatment is not completed at this time and has not met the original goals when the treatment was started.
I understand that CareSource will only cover what remains of the orthodontic treatment costs as the result of my termination of care with this health partner if termination is not the result of non- compliance initiated by the providing dentist.

Parent/Guardian/Member (if over 18 yrs old) Signature:	Date: