CareSource

Orthodontist Confirmation Form

Date: _____

Dear Orthodontia Health Partner: _____

(Member name) has been referred to you for an orthodontia workup and possible treatment. S/he will contact your office to make an appointment. Initial evaluation by the referring dentist suggests this patient has a severe handicapping condition** and may benefit from orthodontia treatment. If, after examination, you do not feel that the member meets CareSource/ODJFS criteria as having the most severe handicapping orthodontic condition, or is not a candidate for comprehensive orthodontic treatment at this time, please complete this form and return it to CareSource.

Following your workup of the patient, please confirm:

This patient is not a suitable candidate for orthodontia treatment for the following reason:

_____

_____

_____

_____

(CareSource will notify the patient that services are not authorized.)

Please fax this letter to CareSource at **1-888-752-0012** or send to:

CareSource
P.O. Box 1307
Dayton, OH 45401-1307

Patient Contact Information

Patient Name and Address:
CareSource Member ID Number:
Address:
Phone:

** CareSource defines a severe handicapping condition as one that severely impairs the patient's ability to eat or speak properly or is associated with significant structural and/or skeletal abnormalities. Imperfections of teeth alignment and bite asymmetry that do not impair mastication and other abnormalities that are primarily cosmetic do not qualify as a severe handicapping condition.

Note: Approved prior authorizations are contingent upon the eligibility of member at the time of service and the claim timely filing limits. Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent upon eligibility and benefits (and other factors). Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.