

**AmeriHealth Caritas Pennsylvania/AmeriHealth Caritas Pennsylvania (PA)
Community HealthChoices (CHC) Orthodontic Continuation of Care (OCOC)
Submission Form**

Date: _____

Patient information		
Name (first and last):	Date of birth:	ID number:
Patient's plan name (check one): <input type="checkbox"/> AmeriHealth Caritas Pennsylvania <input type="checkbox"/> AmeriHealth Caritas PA CHC		
Provider information		
Dentist name:	Provider NPI number:	Location ID number:
Address:	City, state, ZIP:	Area code and phone number:
Name of previous insurer (if available) that issued original approval:		
Banding date:	Number of months of active treatment previously performed:	
Did your office band this patient? (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Months of active treatment being requested (note one D8670 = 3 months of treatment):		
Note: If no active treatment is being requested, please submit a prior authorization request per the Dental Provider Manual Supplement, for orthodontic retention (D8680).		
Additional information required:		
<ul style="list-style-type: none"> • Orthodontic photographs depicting current orthodontic status • ADA claim form from 2019 or later containing the number of D8670s being requested 		
Submission process: Submit Orthodontic Continuation of Care forms, photographs, and requests on ADA forms marked "Orthodontic Continuation of Care Request." Note in section 35 the number of D8670s being requested (one D8670 = 3 months of treatment). Materials can be submitted via:		
<ul style="list-style-type: none"> • Fax: 1-262-834-3589 • Mail: [Indicate the appropriate AmeriHealth Caritas Pennsylvania plan name] Orthodontic COC c/o DentaQuest P.O. Box 2906 Milwaukee, WI 53201-2906 • Electronic claims via DentaQuest's provider portal: https://www.dentaquest.com/en/providers/pennsylvania • Electronic submission via clearinghouses using Payer ID CX014 		