

KENTUCKY MEDICAID PROGRAM
ORTHODONTIC FINAL CASE SUBMISSION

RECIPIENT NAME _____

MEDICAID I.D. # _____

DOCTORS NAME _____ PROVIDER # _____

DATE OF BANDING _____ FINISHED DATE _____

COPY OF BEGINNING AND FINAL RECORDS ENCLOSED- YES ☐ NO ☐

IF NO EXPLAIN _____

WAS TREATMENT COMPLETED ACCORDING TO ORIGINAL TREATMENT PLAN

SUBMITTED ? YES ☐ NO ☐ IF NO EXPLAIN _____

DID THE PATIENT COMPLY WITH TREATMENT PLAN ? YES ☐ NO ☐

IF NO EXPLAIN- _____

WAS ORTHODONTIC SURGERY PART OF TREATMENT ? YES ☐ NO ☐

IF YES, WHAT PROCEDURE WAS PERFORMED? _____

DOES THE PROVIDER CONSIDER THE RESULTS EXCELLENT ☐

SATISFACTORY ☐ POOR ☐ INCOMPLETE ☐

EXPLAIN _____

PROVIDERS TOTAL FEE (FOR TREATMENT) _____

PRIOR- AUTHORIZATION NUMBER

SIGNATURE

DATE

INITIAL SUBMISSION _____

SIX MONTH REPORT _____

FINAL CASE _____