CareSource

# Orthodontic Continuation of Care Form

**Member ID Number:** _____

**Member Name:** _____

**Date of Birth:** _____

**Name of previous health partner that issued approval:** _____

**Banding date:** _____

**Balance expected for future dates of service:** _____

**Services remaining to be covered:** _____

**Additional information required:**

Documentation listing services to be rendered, which may include ADA form.

If the member is transferring from another insurance or Medicaid program: a copy of original orthodontic approval.

If the member is private pay or transferring from commercial insurance please provide the original diagnostic photographs, radiographs and supportive documentation.