Orthodontic Continuation of Care Submission Form

Date:		
Patient information		
Name (first & last):	Date of birth:	Medicaid ID#:
Address:	City, State, ZIP:	
Area code and phone number:	Plan name:	
Provider information		
Dentist name:	Provider NPI #:	Specialty:
Address:	City, State, ZIP:	
Area code and phone number:		
Name of previous vendor that issued original approval:		
Banding date:	Case rate approved by previous vendor:	
Amount paid for dates of service that occurred prior to UnitedHealthcare:		
Amount owed, if any, for dates of service that occurred prior to UnitedHealthcare:		
Balance expected for future dates of service:		
Numbers of adjustments remaining:		

Additional information required:

☐ If the member is transferring from an existing Medicaid program:
A copy of the original orthodontic approval with related payment history.

☐ If the member is private pay or transferring from a commercial insurance program:
Original diagnostic photos or OrthoCad equivalent, radiographs (optional) and related payment history.

Submit to: UnitedHealthcare Dental
Attn: Pre-authorizations
P.O. Box 588
Milwaukee, WI 53201-2906

1-888-445-9817