MAP 559 (REV.12/95)

KENTUCKY MEDICAID PROGRAM

6 MONTH ORTHODONTIC PROGRESS

PATIENT IN ACTIVE TREATMENT

DATE_____

PROVIDER NAME _____ PROVIDER NUMBER_____

PROVIDER TOTAL FEE (FOR TREATMENT)_____

STREET ADDRESS_____

CITY, STATE AND ZIP_____

PHONE NUMBER_____

PATIENTS NAME _____ M.A.I.D. #_____

PRIOR- AUTHORIZATION # (INTIAL SUBMISSION)_____

BANDING DATE (START OF TREATMENT)_____

MONTH DAY YEAR

DATE	TREATMENT(SPECIFY EXACT PROCEDURE)

[] TREATMENT IS PROGRESSING WELL AND IS ON SCHEDULE. (PLEASE LIST PATIENT VISITS ABOVE.)

[] TREATMENT IS BEHIND SCHEDULE. (IF CHECKED, PLEASE GIVE A BRIEF EXPLANATION OF CIRCUM-STANCES. PLEASE LIST ALL ATTEMPTS TO CONTACT PATIENT BY DATE, METHOD AND RESULT.)

DESCRIBE PROGRESS AS IT RELATES TO ORIGINAL TREATMENT PLAN.

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ACCORDING TO MY RECORDS THE PATIENT IS:

KEEPING HIS / HERS APPOINTMENTS YES [ ] NO [ ]

PRACTICING GOOD ORAL HYGIENE YES [ ] NO [ ]

TAKING CARE NOT TO BREAK THE ORTHODONTIC APPLIANCES YES[ ] NO[ ]

_____

SIGNATURE OF ORTHODONTIST

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6 MONTH PROGRESS PRIOR AUTHORIZATION NUMBER