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 INITIAL SUBMISSION SIX MONTH REPORT FINAL CASE

DATE