**Dental Continuation of Care Request Form – Crowns/Inlays/Onlays**

*Note: Only orthodontia, crowns, inlays and onlays will be considered for Continuation of Care exceptions.*

*For orthodontia, no action is required.*

|  |  |  |
| --- | --- | --- |
| Date: | Form Completed By: | Phone #: |
| **REASON FOR REQUEST** |
| *Provider no longer participates with the dental network (must not have termed for cause by the Plan)* |
| **MEMBER INFORMATION** |
| *Member ID:* | *Subscriber Name:* |
| *Patient Name:* | *Date of birth:* |
| *Street Address:* | *City, state, ZIP:* |
| *Home Phone #:* |
| **DENTAL PROVIDER INFORMATION** |
| *Dental Provider Name:* | *NPI or TIN:* |
| *Street Address:* | *City, state, ZIP:* |
| *Office Phone #:* | *Specialty:* |
| *Date of Initial Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**How long is the treatment expected to take to complete? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**How many visits are being requested? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**How often is the patient being seen? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**When is the patient’s next appointment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |

*Provide Instructions on where to send form*

*Disclosures/Disclaimers*