**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*