MY HEALTHY CHILD GRANT FUND

ORTHODONTIA PROVIDER ATTESTATION

Child's Name: _____

Child's Medicaid ID#: _____

Child's assigned Dental Plan:

☐ Dentaquest ☐ MCNA ☐ Liberty ☐ Envolve Dental (prior to 12/1/18)

This signed letter is an attestation that a prior authorization for orthodontia treatment has been submitted to the member's dental plan (as indicated above) within the last twelve months and denied based on medical necessity criteria as outlined in the August 2018 Dental Services Coverage Policy. A denial was not rendered due to missing documentation.

To determine medical necessity, the following items were submitted with the prior authorization requests and can be made available as needed:

☐ Diagnostic casts

☐ Photographs

☐ Radiographs (panoramic and cephalometric)

☐ Orthodontic Criteria Index Form (complete with signature)

☐ Narrative including the diagnosis and treatment plan

Provider Name: _____

Provider Signature: _____

Date: Click here to enter a date.

RETURN SIGNED FORM TO:

NCC Name:_____ NCC Email:_____

NCC Phone: _____ NCC Fax: _____