Government of the District of Columbia
Department of Health Care Finance

District of Columbia
Orthodontic Continuation of Care Form

Date: _____

Patient Information		
Name (First & Last):	Date of Birth:	Medicaid ID#:
Address:	City, State, Zip Code:	Area Code & Phone number:
New Health Plan Name:		
Provider Information		
Dentist Name:	Provider NPI #:	Location ID #:
Address:	City, State, Zip:	Area Code & Phone number:

Name of the previous Health Plan that issued the original approval: _____

Banding Date: _____ Percentage of original treatment time completed: _____

Estimated length of treatment remaining: _____

Amount paid for dates of service that occurred prior to DC Medicaid: _____

Amount owed for dates of service that occurred prior to DC Medicaid: _____

Balance expected for future dates of service: _____

Remaining services and quantities to be paid from prior approval:

_____

_____

_____

Additional information required:

- ❑ If the patient is transferring from an existing Medicaid program: A copy of the original orthodontic approval and diagnostic photos.
- ❑ If the patient is private pay or transferring from a commercial insurance program: Original diagnostic photos or radiographs.

Submit to: Comagine Health

https://comaginepp.zeomega.com