REQUEST FOR
MEDICALLY NECESSARY ORTHODONTIC COVERAGE

Mail to: **Dental Care Plus Group**
100 Crowne Point Place
Cincinnati, OH 45241

Patient's Name:	**Member Number:**	**Birth Date:**
Subscriber's Name:	**Employer Group:**	**Group Number:**
Craniofacial Team or Specialist Managing Patient:	**Phone Number:**	
Orthodontist's Name:	**Orthodontist's Phone Number:**	
Office Contact Person:		

Medically necessary orthodontic coverage is limited to the treatment of severe, dysfunctional, handicapping malocclusions caused by craniofacial anomalies that endanger life.

To apply for coverage, please describe the qualifying craniofacial condition or handicapping skeletal malocclusion that has been diagnosed for this patient:

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Patients qualifying for medically necessary orthodontic coverage must have been evaluated and diagnosed by the following (please indicate the specialist(s) name in the boxes provided):

- a geneticist; and
- a craniofacial team or a specialist directly affiliated with a craniofacial team that validates the craniofacial condition or skeletal malocclusion.

Name of Geneticist:	Phone:
Name of Craniofacial Team or Affiliated Specialist:	Phone:

Along with a completed Pretreatment Estimate, please provide the orthodontic case analysis and treatment plan for Phase : ☐ I ☐ II ☐ III

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Records Required:

To determine eligibility for any severe, dysfunctional, handicapping malocclusion caused by craniofacial anomalies, the following documentation must be provided:

- A copy of the report issued by the geneticist as part of the craniofacial team diagnosing the craniofacial condition or skeletal malocclusion
- Cephalograms & tracings (age appropriate)
- Diagnostic casts (upon request)
- Intraoral photos (upon request)
- Radiographs (upon request)
- Photographs (upon request)
- Other information (upon request) may be required to be considered for coverage

This application and the above records must be returned with a completed Pretreatment Estimate.

NOTE:

THIS IS AN APPLICATION ONLY AND IN NO WAY GUARANTEES COVERAGE OR PAYMENT FOR ANY ORTHODONTIC CONDITION OR TREATMENT.