DELTA DENTAL®

Directions for Submitting
'Treating Dentist Attestation for Orthodontic Coverage'

Please submit a completed 'Treating Dentist Attestation for Orthodontic Coverage' form with the applicable information circled and filled in, as necessary. This document must be received to accurately determine if the case qualifies for orthodontic coverage. A new claim, with the completed 'Treating Dentist Attestation for Orthodontic Coverage' form must be submitted for review and decision about coverage.

Please submit a new claim and the completed form through your normal claim submission channel:

Electronic Claim Submissions:

- You can use the Dental Office Toolkit® (DOT) or your electronic claim submission process to submit your claim and attachment. These are the preferred methods of claim submission to Delta Dental.

Paper Claim Submissions:

- Paper claims with supporting documentation for the following Delta Dental plans and programs should be mailed to the applicable address listed below:

  Michigan, Indiana, Ohio, North Carolina

  Delta Dental
  P. O. Box 9085
  Farmington Hills, MI 48333-9085

TREATING DENTIST ATTESTATION FOR ORTHODONTIC COVERAGE

I attest that [PATIENT NAME] _____ has had an examination in compliance with all applicable state laws and regulations, including, subject to the below, review of [HIS/HER/THEIR] most recent diagnostic digital or conventional radiographs or other equivalent bone imaging suitable for orthodontia, and have determined that [HIS/HER/THEIR] oral health is stable for orthodontic treatment meeting all the conditions below:

☐ Periodontal Status: the patient has no active periodontal disease or has been referred for treatment of gingival / periodontal condition and otherwise has been cleared for orthodontic treatment.

☐ Restorative Status: the patient has no urgent or emergent restorative needs or has been referred to a dentist for treatment and otherwise has been cleared for orthodontic treatment.

☐ Soft Tissue Status: the patient has no pathologic conditions or suspicious lesions (cysts, tumors, other hard or soft tissue lesions) or the oral-facial complex or has been referred and otherwise has been cleared for orthodontic treatment.

☐ The most recent diagnostic digital or conventional radiographs or other equivalent bone imaging (i) have been reviewed by myself as a licensed dentist, (ii) were used in consultation with myself and/or another provider who had direct access to the patient; or (iii) have been determined to be unnecessary at this time in my clinical judgment based on the totality of the circumstances.

☐ Has an established dental home or other dentist that the patient can physically access for dental emergencies arising from the treatment.

I certify that I am the treating dentist for the above-mentioned patient and I will oversee the treatment plan purposed and submitted in the applicable orthodontic claim(s).

Treating Dentist Name: _____

Treating Dentist State License Number: _____

Provider NPI Number: _____

Tax Identification Number: _____

Treating Dentist Signature: _____

This form must be filled out <u>completely</u> for the claim to be considered for benefit payment. All Services provided are subject to audit.