ORTHODONTIC TRANSITION OF CARE

What is Orthodontic Transition of Care?

Orthodontic transition allows patients who are under an orthodontist's care through another dental insurance plan to continue seeing the same orthodontist that was treating their case prior to becoming a member of LIBERTY Dental Plan.

How does a member get started?

In order to be considered for orthodontic transition, the subscriber needs to complete an Orthodontic Transition of Care Summary form and send it to LIBERTY Dental Plan.

Subscribers may download the form at **www.libertydentalplan.com/scc**. Completed and signed forms should be sent via mail to:

LIBERTY Dental Plan
Attn: Claims – Ortho TOC
PO Box 26110
Santa Ana, CA 92799

Or via fax to:

(949) 270-0103
Attn: Claims – Ortho TOC

Are there any exceptions?

Any pre-orthodontic treatment, orthodontic consultation, and diagnostic workup will not be considered for transition. LIBERTY Dental Plan orthodontic benefit maximums, deductibles, co-payments, limitations, and exclusions will apply.

What happens next?

LIBERTY Dental Plan staff will verify patient eligibility and review the form for completeness. LIBERTY will work directly with the treating orthodontist to obtain the necessary supporting documentation. Upon approval, the treating orthodontist is notified and the determination is noted in the system for future reference. Submitted claims will be paid accordingly.

Orthodontic Transition of Care Summary

Patient Name: _____

Subscriber/Insured's Name: _____

Subscriber/Insured's ID Number: _____

Treating Orthodontist: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: ( ) - _____ Fax: ( ) - _____

Please provide the following information for the above named patient:

Original diagnosis/treatment plan: _____

_____

Date treatment initiated *(mm/dd/yyyy)*: _____

Summary of treatment remaining for completion: _____

Estimated completion date *(mm/dd/yyyy)*: _____

Remaining financial obligation (patient amount/insurance amount): _____

Is there another insurance payment anticipated prior to LIBERTY Dental Plan's coverage effective date? *(circle one)* **YES** **NO**

If so, amount expected: **$.**

Please fax or mail this form along with a copy of the patient's chart and patient ledger or Evidence of Payment (EOP) to:

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PO Box 26110
Santa Ana, CA 92799

Fax: (949) 270-0103
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Patient or Guardian:

In accordance with the requirements and standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), specifically regarding Protected Health Information (PHI), please authorize with your signature the release of your or your dependent's patient records to LIBERTY Dental Plan.

Patient or Guardian Signature: _____ Date: _____