



NORTH CAROLINA MEDICAID PROGRAM

ORTHODONTIC TREATMENT TERMINATION REQUEST

Date: \_\_\_\_\_

Return this letter to:

PA  
PO Box 31188  
Raleigh, NC 27622-1188

Recipient name: \_\_\_\_\_

Medicaid ID #: \_\_\_\_\_

Months in treatment = \_\_\_\_\_ Estimated months needed to complete treatment = \_\_\_\_\_

Date of termination = \_\_\_\_\_

Reason for termination (check box and attach any supporting documentation):

- recipient moved out of state
- recipient transferred to another provider (specify) \_\_\_\_\_
- recipient death
- recipient non-compliance
- other (specify) \_\_\_\_\_

Retainers delivered (please circle):     Upper    yes    or    no                      Lower    yes    or    no

Date retainers delivered:                      \_\_\_\_\_

Number of paid maintenance visits:                      \_\_\_\_\_

If the recipient was only banded, Medicaid may require that a percentage of the banding fee be refunded to the program. Medicaid will contact the provider to make arrangements for the refund.

Provider number:                      \_\_\_\_\_

Provider name:                      \_\_\_\_\_

Provider address:                      \_\_\_\_\_

Provider phone:                      \_\_\_\_\_

Fax this form to CSC at: (855) 710-1964