

**NORTH CAROLINA MEDICAID PROGRAM  
ORTHODONTIC TREATMENT TERMINATION REQUEST**



**Note:** Submit electronically in the NCTracks Prior Approval Portal with procedure code D8680 as the requested service and indicate the request is for termination of treatment. Attach this completed Orthodontic Treatment Termination Request Form and a copy of the recipient's treatment notes from the initial visit through the date of termination along with supporting documentation of when and how attempted contacts were made to the recipient. Attach final photographic images if deband was rendered.

DATE:	RECIPIENT NAME:	MEDICAID ID NUMBER:
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DATE OF TERMINATION:	NUMBER OF PAID MAINTENANCE VISITS:
DATE OF DEBANDING:	UPPER RETAINER DELIVERED? YES NO
MONTHS IN TREATMENT:	LOWER RETAINER DELIVERED? YES NO
ESTIMATED MONTHS NEEDED TO COMPLETE TREATMENT:	DATE RETAINERS DELIVERED:

REASON FOR TERMINATION:	Recipient moved out of state Recipient non-compliance Parent/Guardian request removal Recipient transferred to another provider: (specify) _____ Other: (specify) _____	Recipient joined military Recipient removed appliances Recipient death
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COMMENTS:
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If the recipient was only banded, Medicaid may require that a percentage of the banding fee be refunded to the program. This is based on individual case consideration and the circumstances surrounding case termination. In these cases, Medicaid will contact the provider to make arrangements for the refund.

BILLING PROVIDER NPI:	
BILLING PROVIDER NAME:	
SERVICE LOCATION ADDRESS:	
SERVICE LOCATION PHONE:	