

KENTUCKY MEDICAID PROGRAM ORTHODONTIC SERVICES AGREEMENT

The Kentucky Medicaid Program and _____,
a participating provider of orthodontic services, mutually agree to the following:

1. Comprehensive orthodontic services have been pre-authorized for _____,
_____ a currently eligible Medicaid recipient;
2. In return for an initial fee as specified by the Department for Medicaid Services, and effective upon receipt of such fee, the above-named provider agrees to provide the pre-authorized treatment as specified in the approved treatment plan;
3. If the recipient moves from the initial provider's medical service area after the banding and appliances are placed, making necessary a change in providers, the initial provider agrees to submit a patient referral form accompanied by a letter outlining treatment status: 1) dates seen, 2) treatment given, 3) progress made with prorated fee to Unisys. This information will be used by the orthodontic consultants to determine a prorated fee for the services provided;
4. As part of the aforementioned initial fee, the provider agrees to provide, at no additional cost to the Department or the recipient, all retainers necessary to complete the Phase of treatment;
5. Pre-authorizations will not be approved unless the recipient's teeth have been properly cleaned and all general dentistry, i.e., fillings, root canals, etc., have been completed;
6. If the recipient or former recipient fails to return for the visits, the provider must initiate three (3) written contacts, or two (2) written and two (2) verbal (telephone) contacts, with the patient and/or his/her family, to solicit the patient's return to treatment. The final contact must be by certified letter with the returned receipt retained in the patient record. If a patient fails to respond to the contacts, the provider is relieved of the responsibility for providing retention services unless the patient returns for such services within (6) months of the last contact by the provider;
7. The provider will submit to the Medicaid Program beginning and finished records consisting of: a panoramic x-ray, a cephalometric x-ray with tracing, intraoral and extraoral facial pictures (both frontal and profile), and properly occluded and trimmed models at the conclusion of the required course of treatment. Failure to submit finished records within three (3) months after completion of treatment will result in a request for recoupment of payments made to the provider. Additional measures may be made to remove the provider from the Orthodontic Program.

Signature: _____
Participating Provider

By Agency Representative: _____

Date: _____
License Number: _____

Date: _____
Title: _____