MAP- 700

KENTUCKY MEDICAID PROGRAM
ORTHODONTIC FINAL CASE SUBMISSION

RECIPIENT NAME_____

MEDICAID I.D. #_____

DOCTORS NAME_____ PROVIDER #_____

DATE OF BANDING_____ FINISHED DATE_____

COPY OF BEGINNING AND FINAL RECORDS ENCLOSED- YES [ ] NO [ ]

IF NO EXPLAIN_____

WAS TREATMENT COMPLETED ACCORDING TO ORIGINAL TREATMENT PLAN

SUBMITTED ? YES [ ] NO [ ] IF NO EXPLAIN_____

_____

_____

DID THE PATIENT COMPLY WITH TREATMENT PLAN ?YES [ ] NO [ ]

IF NO EXPLAIN-_____

_____

WAS ORTHOGNATHIC SURGERY PART OF TREATMENT ? YES [ ] NO [ ]

IF YES, WHAT PROCEDURE WAS PERFORMED?_____

DOES THE PROVIDER CONSIDER THE RESULTS EXCELLENT [ ]

SATISFACTORY [ ] POOR [ ] INCOMPLETE [ ]

EXPLAIN_____

_____

PROVIDERS TOTAL FEE (FOR TREATMENT)_____

PRIOR- AUTHORIZATION NUMBER
INITIAL SUBMISSION_____
SIX MONTH REPORT_____

_____
SIGNATURE

_____
DATE