HEALTHPLEX
THE DENTAL BENEFIT EXPERTS℠

MEDICAID MANAGED CARE INTERCEPTIVE ORTHODONTIC FORM

PATIENT NAME: _____ MEDICAID ID #: _____

DATE OF BIRTH: _____ GROUP NAME/NUMBER: _____

PATIENT ADDRESS: _____

INSTRUCTIONS:

1. Please complete the patient information above and provider information below.
2. Please complete the following sections and submit this form with the appropriate member records (photos, radiographs).

ADA CODE REQUESTED:	DESCRIPTION:	FEE REQUESTED:

INTERCEPTIVE ORTHODONTIC APPLIANCES (CHECK ONE OR MORE IF APPLICABLE):

❑ Hyrax	❑ Pendulum	❑ Lip Bumper
❑ Trans-Palatal Arch	❑ Lower Lingual Holding Arch	❑ Habit Breaker Fixed
❑ Head Gear	❑ Reverse Pull Head Gear	❑ Lower Expansion Device
❑ Removable Bite Plate	❑ Herbst	❑ Twin Block

❑ Orthodontic Brackets: _____ Upper Arch _____ Lower Arch

❑ Other Appliances: _____

TREATMENT PLAN/NARRATIVE (IF APPLICABLE):

_____

_____

_____

_____

PRACTICE NAME: _____ SITE NUMBER: _____

ADDRESS: _____

TELEPHONE: _____ TAX ID: _____

ORTHODONTIST SIGNATURE: _____ DATE: _____