



**NORTH CAROLINA MEDICAID PROGRAM
ORTHODONTIC POST TREATMENT SUMMARY**

Date: _____

Return this letter to:

PA
PO Box 31188
Raleigh, NC 27622-1188

Recipient name: _____

Recipient ID #: _____

Active phase of treatment has been completed. Date of debanding: _____

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

Date retainers delivered: _____

Results obtained (please circle): excellent good fair poor

Assessment of recipient cooperation: excellent good fair poor

Comments: _____

Number of paid maintenance visits: _____

If fewer than 12 maintenance visits were paid, records review is required to substantiate the final claim payment. If it is determined that treatment was not "completed" but rather "terminated", the final payment will not be allowed.

Provider number: _____

Provider name: _____

Provider address: _____

Provider phone: _____

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