Maternal and Child Health Bureau
Division of Children with Special Health Care Needs

ORTHODONTIC PROGRAM PLAN OF CARE

☐ Initial ☐ Revision

ORTHODONTIST Name _____

Address _____

_____

ORTHODONTIC TREATMENT

Early/ interceptive _____ Months

*Treatment of primary or mixed dentition to eliminate underlying cause, correct or reduce severity of malocclusion and functional impairment. Limit of **15 months**. Provide justification if additional time needed.*

Comprehensive _____ Months

*Treatment of transitional, adolescent, or adult dentition to achieve satisfactory correction of malocclusion and functional impairment. Limit of **30 months**. Provide justification if additional time needed.*

SURGICAL TREATMENT

☐ Unable to determine need for surgery at this time. Will submit updated plan of care if surgery is required in conjunction with orthodontic treatment.

☐ Do not anticipate need for surgery -- satisfactory correction of functional impairment can be achieved through orthodontic treatment alone.

☐ Surgery required in conjunction with orthodontic treatment. Satisfactory correction of functional impairment cannot be achieved by orthodontic treatment alone.

Describe planned services, including sequence and timing of services required for satisfactory outcome. Plan of care may be revised or updated at any time up to patient's 18th birthday. Reimbursement limited to authorized services provided to eligible individuals on or before last day of month of 21st birthday.

Additional information, special considerations or concerns (especially those that may require DHEC follow up to assure successful treatment).

Routine general dental care during orthodontic treatment. (DHEC will monitor as needed to help assure compliance.)

Dental cleaning every _____ months

_____ Orthodontist Signature

_____ Date Completed

Regional CSHCN office address

ID# _____ DOB _____

Patient Name _____

Patient Address _____

_____

RETURN TO REGIONAL CSHCN OFFICE

(Plan of care must be on file at DHEC for reimbursement for program services.)

ORTHODONTIC PLAN of CARE

PURPOSE:

To document orthodontist's treatment plan for patients enrolled in the CSHCN Orthodontic Program. This form is completed after approval for program services and completion of initial diagnostic evaluation. The form may be revised and updated as needed. Regional CSHCN office may authorize covered services (see policy manual) included on plan of care without additional central office review and approval.

INSTRUCTIONS:

Regional CSHCN office staff enters following (or affixes label):

- Return mailing address; and
- Patient identifying information (MCI number, name, date of birth).

Orthodontist enters:

- Name and mailing address;
- Description of orthodontic and other services required to achieve satisfactory correction of functional impairment;
- Signs and dates the form; and
- Returns to the regional CSHCN office.

OFFICE MECHANICS AND FILING

The original signed copy of the form is filed in the health record with other medical reports.

A copy of the form is sent to the Division of Children with Special Health Care Needs (CSHCN).