NORTH CAROLINA MEDICAID PROGRAM
ORTHODONTIC TREATMENT EXTENSION REQUEST

Note: Providers are reminded that reimbursement for extended orthodontic treatment is limited to the remaining number of periodic maintenance visits for that recipient (total of twenty-three visits).

Date: _____

Return this letter to:

PA
PO Box 31188
Raleigh, NC 27622-1188

Recipient name: _____

Medicaid ID #: _____

Months in treatment = _____

Estimated months needed to complete treatment = _____

Reason for extension: _____

_____

_____

Number of paid maintenance visits: _____

Provider number: _____

Provider name: _____

Provider address: _____

Provider phone: _____

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