United Healthcare

Thank you for choosing UnitedHealthcare

UnitedHealthcare APPLICATION FOR ORTHODONTIC TRANSITION OF CARE

Please complete the employee information. Provide this form along with your new ID Card to your orthodontist. Your orthodontist will complete this form and submit the information with your first claim to UnitedHealthcare. If your provider has a preferred form that they would like to use, we will accept their form.

Employee Information

Employee Name:	Subscriber ID:	
Address:	City:	State/Zip:
Home Phone No:	Work Phone No:	
Employer Name:	Plan Effective Date:	
Patient Name:	Patient Date of Birth:	

Dental Provider Information

Practice Name:	Treating Dentist:	
Address:	City:	
State/Zip:	Phone Number:	

Treatment Information

Treatment Start Date:	Type of Service: **Orthodontics**
Prior Carrier Paid Amount: **$**	
Total of Copayments Toward Orthodontic Contract Paid By Member: $	
Length of Treatment:	
Detailed Treatment Plan:	
Additional Services Needed:	
Number of Months Remaining:	
Banding Date:	
Prior Carrier Paid Amount:	
Total Balance Due to the Provider:	
Amount of Copay Already Paid by member (if applicable):	

Authorization to Release Records

I authorize my dental provider to provide UnitedHealthcare dental information concerning my treatment. This information will be used to determine the patient's eligibility for transition of care benefits under the new plan.

_____ _____

Patient's Signature / Parent or Guardian's Signature if Applicant is a Minor **Date**

If you have any questions about your plan, please call 1-866-660-7181. Also, you may find your member website, myuhc.com, a great resource, We are happy to help.