Keystone First/Keystone First Community HealthChoices (CHC) Orthodontic Continuation of Care (OCOC) Submission Form



Patient information			
Name (first and last):		Date of birth:	ID number:
Patient's plan name (check one): ☐ Keystone First ☐ Keystone First CHC			
Provider information			
Dentist name:		Provider NPI number:	Location ID number:
Address:		City, state, ZIP:	Area code and phone number:
Name of previous insurer (if available) that issued original approval:			
Banding date:	Nı	Number of months of active treatment previously performed:	
Did your office band this patient? (check one) ☐ Yes ☐ No			
Months of active treatment being requested (note one D8670 = 3 months of treatment):			
Note: If no active treatment is being requested, please submit a prior authorization request per the Dental Provider Manual Supplement, for orthodontic retention (D8680).			
Additional information required:			
Orthodontic photographs depicting current orthodontic status			
 ADA claim form version 2019 or later containing the quantity of D8670s being requested 			
Submission process — Submit Orthodontic Continuation of Care forms, photographs, and requests on ADA forms with "Orthodontic Continuation of Care Request" noted in section 35, and the number of D8670s being requested (one D8670 = 3 months of treatment) on the service line. Materials can be submitted via:			
• Fax: 1-262-834-3589			
 Mail: [Indicate the appropriate Keystone First p c/o DentaQuest P.O. Box 2906 Milwaukee, WI 53201-2906 	ılan nar	me] Orthodontic COC	
Electronic claims via DentaQuest's provider portal:			

www.keystonefirstpa.com I www.keystonefirstchc.com

https://www.dentaquest.com/en/providers/pennsylvania
 Electronic submission via clearinghouses using Payer ID CX014