Delta Dental Smiles for Kids

Orthodontic Treatment Clearance Form

Enrollee Name: _____

Enrollee Date of Birth: _____

Enrollee Medicaid ID: _____

To the best of my knowledge, this enrollee exhibits satisfactory oral hygiene, and has completed all recommended treatment regarding general dentistry and preventive care.

Orthodontic Provider Name: _____

Orthodontic Provider Signature: _____

Provider NPI: _____

Date: _____

(this date must be within 6 months of Pre-authorization submission)