

**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:
HP Prior Approval Unit
Attn: Orthodontic Review Board
P.O. Box 31188
Raleigh, NC 27622

Recipient name: _____

Medicaid ID #: _____

Months in treatment = _____

Estimated months needed to complete treatment = _____

Number of paid maintenance visits: _____

Reason for extension: _____

Provider number: _____

Provider name: _____

Provider address: _____

Provider phone: _____

<p>HP Orthodontic Prior Approval Use Only</p> <p>Extension Request: Approved () Denied ()</p> <p>Revised Prior Approval End Date: _____</p>
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