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

Keystone First | Keystone First Community HealthChoices

Date: _____

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:	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 plan name] Orthodontic COC
  c/o DentaQuest
  P.O. Box 2906
  Milwaukee, WI 53201-2906
- Electronic claims via DentaQuest's provider portal:
  https://www.dentaquest.com/en/providers/pennsylvania
- Electronic submission via clearinghouses using Payer ID CX014

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