## **OrthoCAD Submission Form**

Date:\_\_\_\_\_

Patient Information			
Name (First & Last)		Date of Birth:	SS or ID#
Address:		City, State, Zip	Area code & Phone number:
Group Name:		Plan Type:	
Provider Information	on		
Dentist Name:		Provider NPI #	Location ID #
Address:		City, State, Zip	Area code & Phone number:
Treatment Requested			
Code: Description of request:			