Maternal and Child Health Bureau
Division of Children and Youth with Special Health Care Needs

ORTHODONTIC PROGRAM PLAN OF CARE

☐ Initial ☐ Revision

ORTHODONTIST

Name _____

Address _____

_____

Phone _____

ORTHODONTIC TREATMENT

Limited _____ Months

Treatment of primary or mixed dentition to eliminate underlying cause, correct or reduce severity of malocclusion and functional impairment. ***Limit of 15 months****. Provide justification if additional time needed.*

Comprehensive _____ Months

Treatment of transitional, adolescent, or adult dentition to achieve satisfactory correction of malocclusion and functional impairment. Limit of 36 months. Provide justification if additional time needed.

SURGICAL TREATMENT

☐ Unable to determine need for surgery at this time. Will submit updated plan of care if surgery is required in conjunction with orthodontic treatment.

☐ Do not anticipate need for surgery satisfactory correction of functional impairment can be achieved through orthodontic treatment alone.

☐ Surgery required in conjunction with orthodontic treatment. Satisfactory correction of functional impairment cannot be achieved by orthodontic treatment alone.

Describe planned services, including sequence and timing of services required for satisfactory outcome. Plan of care may be revised or updated at any time up to patient's 18th birthday. Reimbursement limited to authorized services provided to eligible individuals on or before last day of month of 19th birthday.

Additional information, special considerations or concerns (especially those that may require DHEC follow up to assure successful treatment).

Routine general dental care during orthodontic treatment. (DHEC will monitor as needed to help assure compliance.)

Dental cleaning every _____ months

_____ _____

Orthondontist Signature Date Completed

Regional CYSHCN office address

LABEL

RETURN TO CYSHCN OFFICE
(Plan of care must be on file at DHEC for reimbursement for program services.)

ORTHODONTIC PLAN of CARE

PURPOSE:

To document orthodontist's treatment plan for patients enrolled in the CYSHCN Orthodontic Program. This form is completed and submitted to the Region office along with the Service Request Form and supporting documentation. The form may be revised and updated as needed. CYSHCN may authorize covered services (see policy manual) included on plan of care without additional central office review and approval.

INSTRUCTIONS:

CYSHCN office staff enters following (or affixes label):

- Return mailing address; and
- Patient identifying information (MCI number, name, date of birth).

Orthodontist enters:

- Name; mailing address; and phone;
- Description of orthodontic and other services required to achieve satisfactory correction of functional impairment;
- Signs and dates the form; and
- Returns to the CYSHCN office.

OFFICE MECHANICS AND FILING

This form should be filed in the comprehensive health record according to the Health Record Format located in the Health Record Policy Manual. The comprehensive health record retention schedule applies.