New Jersey FamilyCare Program LIBERTY

Dental Plan

ORTHODONTIC TRANSITION OF CARE

LIBERTY provides Transition of Care for in progress orthodontic treatments which are pre-authorized by a previous carrier.

"Treatment in progress" means that the placement of fixed appliances (band/bond/brackets) has occurred.

In order for LIBERTY to continue payments for orthodontic care in progress, the treating orthodontist must send the following required information:

- An Orthodontic Transition of Care Summary form (see attached form for sample)
- A copy of the claim/authorization (TAR) for treatment, and/or
    - A previous Evidence of Payment (EOP), or
    - Evidence of Benefits (EOB) statements from the previous carrier
- Documentation of the number of orthodontic treatment visits that have been rendered to date.
    - This can be done by providing EOB/EOPs for all payments received for all treatment visits, or
    - A printout from the previous carrier showing all the visits for which payment has been received.
- ADA Claim form for the orthodontic services

Members or providers may download the Orthodontic Transition of Care Form from LIBERTY's website at www.libertydentalplan.com.

Completed forms must be sent within 90 days from the patient's effective date via mail or fax to:

LIBERTY Dental Plan
Attn: Transition of Care Claims
PO Box 401086
Las Vegas, Nevada 89140

Fax: (888) 401-1129
Attn: Claims – Ortho TOC

A LIBERTY staff will verify patient's eligibility and review the Orthodontic Transition of Care Form for completeness. Additionally, to confirm the treatment was authorized by the previous plan administrator, copies of the approved TAR, EOP and/or EOB statements will be reviewed. LIBERTY will determine the number of visits remaining on the benefit and the remaining fee owed to the orthodontic provider.

If necessary, LIBERTY will work directly with the treating orthodontist to obtain necessary supporting documentation.

LIBERTY will process the Orthodontic Transition of Care claims based on the information provided. The treating orthodontist will be notified and the remaining balance will be noted in LIBERTY's claims system for future processing. Claims must be submitted for all future reimbursements on each case.

New Jersey FamilyCare

Orthodontic Transition of Care Summary Form

Patient Name:

Patient D.O.B.:

Subscriber/Insured's Name:

Subscriber/Insured's SSN/ID#:

Treating Orthodontist:

Orthodontist's LIBERTY Provider Number:

Address:

City: **State:** **Zip:**

Phone: ( ) - **Fax: ( ) -**

Please provide the following information for the above named patient:

Original diagnosis/treatment plan (including # of months or # of treatment visits): _____

_____

Date treatment initiated (banding/bonding) (mm/dd/yyyy): _____

Number of treatment visits ("activation" visits) rendered to date (not including band/bond visit): _____

Summary of treatment remaining for completion: _____

_____

Estimated completion date (mm/dd/yyyy): _____

Number of expected remaining treatment ("activation") visits to complete treatment: _____

Original Contract Amount approved by Previous Carrier: **$** _____

Amount Paid by Previous Carrier: **$** _____

Remaining Balance financial obligation: **$** _____

Is there another insurance payment anticipated prior to LIBERTY Dental Plan's coverage effective date
(Circle one) **YES** **NO**

If so, amount expected: **$**_____

Please fax or mail this Orthodontic Transition of Care Summary Form along with a copy of the previous carrier's authorization, Evidence of Payment (EOP) or Evidence of Benefit statements and/or chart notes showing all visits to:

LIBERTY Dental Plan
Attn: Ortho Transition of Care Claims
PO Box 401086
Las Vegas, Nevada 89140

Fax: (888) 401-1129
Attn: Claims – Ortho TOC