AmeriHealth Caritas
District of Columbia

To: AmeriHealth Caritas DC Dental Providers

Date: May 16, 2022

Subject: **Continuation of Care Submission Form Update**

Please note that the Continuation of Care Submission Form is accepted **only** via the United States Postal Service (USPS). The form must be mailed to:

AmeriHealth Caritas DC — Continuation of Care
P.O. Box 654
Milwaukee, WI 53201

You may find the Continuation of Care Submission Form attached to this fax or on page 48 of the Dental Provider Supplement to the Provider Manual located at https://www.amerihealthcaritasdc.com/provider/manuals-guides.aspx.

If you have any questions about this communication, please contact your Provider Account Executive or the Provider Services department at 202-408-2237.

Continuation of Care Submission Form

(Accepted only via the United States Postal Service (USPS))

Date:_____

Patient information

Name (first and last)	Date of birth:	ID number
Address:	City, state, ZIP	Area code and phone number:
Group name:	Plan type:	

Provider information

Dentist name:	Provider NPI number	Location ID number
Address:	City, state, ZIP	Area code and phone number:

Name of previous vendor that issued original approval:

Banding date: **Case rate approved by previous vendor:**

Amount paid for dates of service that occurred prior to AmeriHealth Caritas DC:

Amount owed for dates of service that occurred prior to AmeriHealth Caritas DC:

Balance expected for future dates of service:

Remaining services and quantities to be paid from prior approval:

Additional information required:

☐ **If the member is transferring from an existing Medicaid program, provide a copy of the original orthodontic approval and diagnostic photos**

☐ **If the member is private pay or transferring from a commercial insurance program, provide current diagnostic photos or radiographs**

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