AmeriHealth Caritas
District of Columbia

To: AmeriHealth Caritas District of Columbia Dental Network

Date: August 6, 2025

Subject: Orthodontic Continuation of Care Submission Process Update Effective September 1, 2025

Dear Provider:

AmeriHealth Caritas District of Columbia is implementing a new process for submitting Continuation of Care (COC) requests for transitioning orthodontic cases from one provider to another.

Effective September 1, 2025, providers may submit COC requests electronically through the Skygen Dental Hub. You may still submit by mail using the United States Postal Service (USPS) address below:

AmeriHealth Caritas PA – Authorizations
PO Box 654
Milwaukee, WI 53201

To submit via the Dental Hub, use Payor ID **SCION** at the following link:
https://app.dentalhub.com/app/login

Required documentation for all COC submissions (whether via Dental Hub or USPS) includes:

- Current photographs (**required**)
- Completed Continuation of Care Submission Form, including patient and provider information (**required**)
- A request for the number of units of procedure code D8670, along with the quantity requested for medical necessity review (**required**)
- All applicable records, if available
- Name of the previous insurance or managed care organization, if known
- Original approved authorization for orthodontic treatment from the prior provider, if available

Incomplete submissions or failure to include the required documentation will result in a denial of the COC request.

If you have questions about the submission process or the Dental Hub, please contact Provider Services at **1-855-609-5170**.

Sincerely,

Nathan Fletcher, DDS

Nathan Fletcher, DDS
Dental Director

Continuation of Care Submission Form

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

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

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Please note this form is accepted via USPS and electronically through the Skygen Dental Hub. To submit via the Dental Hub, use Payor ID SCION at the following link: https://app.dentalhub.com/app/login.