Transition of Care Form
For
Orthodontic Treatment

Purpose: *To determine remaining orthodontic benefits available for patients in active orthodontic treatment.*
* Active Orthodontic treatment must have been started while covered under a previous insurance carrier with your current employer. **Humana Specialty Benefits does not guarantee transition of care benefits; all requests are handled on a case-by-case basis.*

Procedure:
If you or your family member have ***not already*** been "banded" for orthodontic treatment, you will need to verify that your orthodontist is listed on the Humana Specialty Benefits Directory.

If you or your family members have ***already*** been banded under the coverage from your previous DHMO/PPO Company, you will probably have no difficulty continuing this coverage as planned. In most situations, you have entered into a monthly payment plan that will supercede any new coverage, which is now being provided.

A copy of the prior carrier explanation of benefits / benefit payments must be included when you submit the Transition of Care form to Humana Specialty Benefits.

In the event you or your orthodontic provider has questions about continuing orthodontic care for you or your family members, please contact Humana Specialty Benefits Customer Care at **1-800-342-5209** for assistance. We will make every effort to make this transition as seamless as possible and will work with your existing orthodontist to either continue the care in progress, or transition the care to a Humana Specialty Benefits contracted provider. **In lieu of standard dental claim form, please submit the following form to your Orthodontist to alert Humana Specialty Benefits to your situation. Upon full completion of the form by the Subscriber and Orthodontist, please submit the form to the address below and allow 30 days for processing:**

Humana Specialty Benefits
P. O. Box 14283
Lexington, Kentucky 40512-4283
Attn: Prefix #XBH

Subscriber Section:

Name of Employee: _____ Subscriber I.D. _____
Daytime Phone Number_____ Employer: _____
Name of dependent in treatment:_____
Relationship to Employee:_____

Orthodontist Section:

Current Orthodontist's Name: _____ Phone Number: (___)_____

Orthodontist Address: _____

Orthodontist Signature: _____ Orthodontist TIN: _____

Date treatment started:_____ Target Completion Date:_____

Total Treatment cost: $_____ Contracted Rate from Previous Carrier: $_____

Previous Carrier Supplement: $_____ Member Co-Payments: $ _____

Total Payments from Previous Carrier: $_____ Paid Member Co-Payments: $ _____
(To avoid delays in processing, please submit copies of the EOB's/ Benefit Payments from Previous Carrier)

Current Balance Owed: $_____
Please note: Future reimbursements will be made on a quarterly basis.