Continuous Orthodontic Coverage Form

(To be completed by the treating Orthodontist)

If patient's previous orthodontic coverage was through an employer dental plan and the patient meets all required conditions, please complete the following (all fields are required):

Enrollee Name:	Previous Plan End Date:
Enrollee ID:	Banding Date:
Employer/Organization:	Orthodontist Name:
Patient Name:	Orthodontist Address:
Previous Dental Plan:	Orthodontist Phone:
Previous Plan Total Financial Obligation:	

Please make sure the following items are complete, enclosed and submitted within 45 days of your plan effective date. DENCAP will coordinate your benefits as necessary.

- Completed claim form – be sure to include banding date
- Explanation of Benefits – show amount previous plan paid and remaining due

Submit this form to:
DENCAP Dental Plans, Inc.
P.O. Box 2548
Detroit, MI 48202