MAP 559 (12-95)

KENTUCKY MEDICAID PROGRAM

SIX MONTH ORTHODONTIC PROGRESS

PATIENT IN ACTIVE TREATMENT

DATE _____

PROVIDER NAME _____ PROVIDER NUMBER _____
PROVIDER TOTAL FEE (FOR TREATMENT) _____
STREET ADDRESS _____
CITY, STATE AND ZIP _____
PHONE NUMBER _____
PATIENT'S NAME _____ M.A.I.D.# _____
PRIOR AUTHORIZATION # (INTIAL SUBMISSION) _____
BANDING DATE (START OF TREATMENT) _____
MONTH DAY YEAR

DATE	**TREATMENT (SPECIFY EXACT PROCEDURE)**

☐ TREATMENT IS PROGRESSING WELL AND IS ON SCHEDULE. (PLEASE LIST PATIENT VISITS ABOVE, LISTING DATE SEEN AND BRIEF DESCRIPTIONS OF TREATMENT.)

☐ TREATMENT IS BEHIND SCHEDULE. (IF CHECKED, PLEASE GIVE A BRIEF EXPLANATION OF CIRCUM-STANCES. PLEASE LIST ALL ATTEMPTS TO CONTACT PATIENT BY DATE, METHOD AND RESULT.)

DESCRIBE PROGRESS AS IT RELATES TO ORIGINAL TREATMENT PLAN.

_____

_____

ACCORDING TO MY RECORDS THE PATIENT IS:

KEEPING HIS / HER APPOINTMENTS YES ☐ NO ☐
PRACTICING GOOD ORAL HYGIENE YES ☐ NO ☐
TAKING CARE NOT TO BREAK THE ORTHODONTIC APPLIANCES YES ☐ NO ☐

_____
SIGNATURE OF ORTHODONTIST