

**Ohio Department of Health
Children with Medical Handicaps Program (BCMh)
Orthodontic Payment Information**

Type or Print Legibly

Fax completed form to 614-564-2501

Client's Name (Last name, First Name)	BCMh Case Number
Initial Exam Date / /	Present Phase of Treatment (Mark Only One) <input type="checkbox"/> Phase I (Deciduous) <input type="checkbox"/> Phase II (Transitional Dentition) <input type="checkbox"/> Phase III (Permanent (Adult) Dentition)
Projected beginning date of this treatment phase / /	Projected ending date of this treatment phase / /

Description of Services	ADA Code	Usual & Customary Charges
Orthodontic Consultant and Records	D8409	
Comprehensive Evaluation	D0160	
Skull Films	D0290	
Cephalograms (Tracing)	D0340	
Panoramic Films	D0330	
Diagnostic Casts (Models)	D0470	
Other:		
Total Charges		

BCMh Action (For BCMh Use Only)

Denial Date / /
Reason

BCMh Approved Phase Payment (FOR BCMh Use Only)

Description of Services	BCMh Code	Amount
Total Amount		

BCMh Special Authorization Nurse Signature

Date