DELTA DENTAL®

Treating dentist attestation

This attestation form is required for CDT codes D8070-D8091, with a total fee of under $2,500. It ensures the patient receives a thorough in-person or virtual examination, diagnosis and treatment plan from a dentist or orthodontist before starting orthodontic care. These steps confirm that the patient's mouth is healthy and ready for orthodontic treatment.

Patient name (first, middle initial, last): _____

Patient date of birth (mm/dd/yyyy): _____

Patient address (street, city, state and zip): _____

_____

Member ID: _____

I attest that the patient named above has had an examination in compliance with all applicable state laws and regulations, including, subject to the below, review of their most recent diagnostic digital or conventional radiographs or other equivalent bone imaging suitable for orthodontia, and have determined their oral health is stable for orthodontic treatment **meeting all five conditions below**:

1. **Periodontal Status:** the patient has no active periodontal disease or has been referred for treatment of a gingival/periodontal condition and otherwise has been cleared for orthodontic treatment.
2. **Restorative Status:** the patient has no urgent or emergent restorative needs or has been referred to a dentist for treatment and otherwise has been cleared for orthodontic treatment.
3. **Soft Tissue Status:** the patient has no pathologic conditions or suspicious lesions (cysts, tumors, other hard or soft tissue lesions) of the oral-facial complex or has been referred and otherwise has been cleared for orthodontic treatment.
4. The most recent diagnostic digital or conventional radiographs or other equivalent bone imaging (i) have been reviewed by me, (ii) were used in consultation with me by another provider who had direct access to the patient, or (iii) have been determined to be unnecessary at this time in my clinical judgment based on the totality of the circumstances.
5. Has an established dental home or other dentist that the patient can physically access for dental emergencies arising from the treatment.

Treating dentist name: _____

State/license number _____

Dentist NPI number: _____

Signature: _____

All services provided are subject to audit.