Transition of Care Form
for
Orthodontic Treatment – ERS of Texas

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 does not guarantee transition of care benefits; all requests are handled on a case-by-case basis.*

Procedure:

- If the member has ***not already*** been "banded" for orthodontic treatment, you will need to verify the orthodontist participation with the State of Texas Dental Choice Plan℠ on our website, ERSdentalplans.com.
- If the member has ***already*** been banded under the coverage from a previous carrier, your claim will be reviewed to continue your orthodontic treatment coverage under the Humana plan.
- 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
- If you have questions about continuing orthodontic care, please contact Customer Care at **855-756-6580** for assistance. We will make every effort to make this transition as seamless as possible and will work with you to continue the care in progress.
- 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
P.O. Box 14359
Lexington, Kentucky 40512-4359
Fax: 888-556-2128

Subscriber Information:

Name of Employee: _____ Subscriber I.D. _____

Daytime Phone Number_____ Employer: _____

Name of patient in treatment:_____

Relationship to Employee:_____

Orthodontist Information:

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

Orthodontist Address: _____

Orthodontist Signature: _____Orthodontist TIN: _____

Date treatment started:_____ Target Completion Date:_____

Total Treatment cost: $_____ Prior Carrier's Contracted Rate: $_____

Prior Carrier Supplemental Payment: $_____

Member Copayments : $ _____

Total Payments Made from Previous Carrier: $_____

Total Payments Made from Member $ _____

(To avoid delays in processing, please submit copies of the EOBs/ Benefit Payments from Previous Carrier)

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