APPLICATION FOR
DENTAL TRANSITION OF CARE

Transition of care is a service that enables you to continue Dental treatment already in progress.

Please submit this form, attaching any Explanation of Benefits (EOB's) from your prior Dental Provider and/or documents (Treatment Plan) from your dentist that verifies the qualification requirements.

Employee Information

Employee Name:	Subscriber Id:	
Address:	City/State:	Zip:
Home Phone No:	Work Phone No:	
Employer Name:	Plan Effective Date:	
Patient Name:	Patient Date of Birth:	

Dental Provider Information

Practice Name:	Treating Dentist:	
Address:	City:	
State/Zip:	Phone Number:	

Treatment Information

Treatment Start Date		Length of Treatment	
Type of Service		Detailed Treatment Plan	
Additional Services Needed		Number of Months Remaining	
Banding Date (orthodontia)		Total balance due to the Provider	
Prior Carrier Paid Amount		Amount Already Paid by the member	

Authorization to release records

I authorize my dental provider to provide Solstice Benefits, Inc. information concerning my treatment. This information will be used to determine the patient's eligibility for transition of care benefits under the new plan.

Patient's Signature / Parent or Guardian's Signature if Applicant is a Minor Date

Solstice Benefits, Inc.
Attn: Claims Department, PO Box 14009, Lexington, KY 40512

1-877-760-2247