Orthodontic Transition of Care

Are you in the middle of Orthodontic treatment (Orthodontia in progress)? Here are a few things you need to know....

Under the DHMO plans, orthodontic treatments are covered for up to a total of 24 months. If a member has orthodontic treatment in progress through another insurance plan before becoming eligible under the Solstice plan, the remaining months of treatment would be covered until the treatment reaches 24 months.

The PPO and DHMO plans do not cover work in progress for a newly effective member who did not have dental insurance coverage prior to the effective date.

Under the DPPO plan, Solstice allows transition of care on orthodontic cases in progress on a prorated basis at the time of implementation only and subject to Lifetime Maximums as applicable. The number of months remaining in treatment, the amount paid under the terminating plan, and the benefit level are taken into consideration when prorating.

To initiate your Orthodontic Transition of Care benefit, all you need to do is have the attached Transition of Care Application completed and submitted to Solstice, along with the a dental ADA claim form and your previous insurance Explanation of Benefits (EOB's), prior to having additional treatment.

Contact Solstice Customer Service at 855-301-4370 or vcs@solsticebenefits.com for additional information or if you have any further questions.

VOLUSIA COUNTY SCHOOLS

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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, P.O. Box 14009, Lexington, KY 40512

1-855-301-4370

Fax: 954-370-1701
e-mail: claims@SolsticeBenefits.com