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Health Canada Santé Canada

Non-Insured Health Benefits
Completion of Active Orthodontic Treatment Form

Provider Information

Name: _____ **Provider Number:** _____

Mailing Address: _____

Client Information

Name: _____ **Client Registration Number:** _____

Mailing Address: _____ **Date of Birth:** _____ (YYYY-MM-DD)

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1. **Date active orthodontic treatment started (YYYY-MM-DD):**

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2. **Date active orthodontic treatment completed (YYYY-MM-DD):**

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3. **Was the original orthodontic treatment plan changed?** ○ YES ○ NO
   If yes, please explain: _____

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4. **Were the objectives of the orthodontic treatment plan accomplished?** ○ YES ○ NO
   If no:
   a. **Please explain:** _____

   b. **Please provide a list of services rendered since orthodontic treatment was initiated including their date of service. (Please attach separate sheet if needed)** _____

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5. **Were retainers inserted?** ○ YES ○ NO
   If no, please explain: _____

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6. **What is the projected duration of retention phase of orthodontic treatment?** _____

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7. **Does the client require additional dental services (restorative, periodontal, etc.)** ○ YES ○ NO
   If yes, please explain: _____

I confirm that the above information is complete and accurate.

_____

Provider Signature **Date** (YYYY-MM-DD)