



## NJ FamilyCare: Attestation of Completed Preventive & Restorative Dental Treatment

### Provider Office

Provider Name:					Office ID#:		
Address:					Office Phone:		
City:		State:		Zip:		Office Fax:	

### Member

Member Name:					Member ID#:		
Address:					Date of Birth:		
City:		State:		Zip:		Phone:	

The Primary Care Dentists (PCD) must certify that all preventive and/or restorative dental treatment needs have been met. **Signature is required.**

**Provider Name**

**Provider Signature**

**Date**

*It is the responsibility of the rendering orthodontist to submit an attestation from the referring or treating primary care dentist that all preventive and dental treatment services have been completed. This attestation may be submitted in lieu of a written narrative on the PCD's letterhead.*