DENTAL CARE FOR CHILDREN WITH SPECIAL NEEDS

Humanitarian Foundation of Grottoes International

All treatment (except initial exams, prophy, fluoride, x rays) must be pre-authorized

FORM #2 - ATTENDING DENTIST PRE-TREATMENT ESTIMATE

Sponsoring Grotto _____ Handicap Condition_____

Child's Name_____ Sex: M / F Birth Date_____

Child's Address _____

Street City State Zip

Parent's Name_____

Parent's Phone # _____ Parent's Email _____

Dentist's Name_____ Dentist's Phone #_____

Dentist's Address _____

Street City State Zip

Dentist's License #_____ Dentist's Tax ID #_____

Tooth # or Letter	Surface	Description of Service	Date of Completion	ADA Code	Dentist's Fee	Grotto Pre-Authorized Fee

IF THIS IS WILL BE HOSPITAL CASE FOR ANESTHESIA, PLEASE LIST THE FOLLOWING ESTIMATED COST FOR PRE-AUTHORIZATION

Hospital_____

Estimated Anesthesia Time_____

Date of Treatment_____

Anesthesia Cost_____

Grotto Pre-Authorized Fee_____

Total Fee_____

Total Grotto Pre-Authorized Fee

_____

Insurance Pays_____

Patient Pays_____

Balance_____

ANY MONEY RECEIVED FROM INSURANCE, ETC. IS TO BE DEDUCTED FROM BILL PRIOR TO SUBMITTING FOR REVIEW AND PAYMENT

Grotto Representative_____ Dentist's Signature_____

Return to Grotto Rep for signature, he will mail paperwork to Humanitarian Foundation office for processing.
Signatures Required