DENTAL CARE FOR CHILDREN WITH SPECIAL NEEDS

Humanitarian Foundation – Grottoes of North America

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_____
Address_____
Street City State Zip
Parent's Name_____
Dentist's Name_____ License #_____
Tax ID #_____
Dentist Address & Phone # _____
Street City State Zip Phone #

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