

## DENTAL CARE FOR CHILDREN WITH SPECIAL NEEDS

## **Humanitarian Foundation of Grottoes International**

## FORM #2 - ATTENDING DENTIST PRE-TREATMENT ESTIMATE

Sponsoring Grotto			Handicap Condition						
Child's	Name		Sex: M / F Birth Date						
Child's	Address								
enn <b>a</b> s z		Street		City		State		Zip	
Parent's	Name								
Parent's	Phone #		Parent's Email						
			Dentist's Phone #						
Dennsts		Street		City		State		Zip	
			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 CASE REQUIRES ANESTHESIA,						Total Fee			
PLEASE LIST THE FOLLOWING ESTIMATED COST FOR PRE-AUTHORIZATION					ED	Total Grotto Pre-Authorized Fee			
	rovider	T 1				T	D	_	
Provider Tax Id  Estimated Anasthasia Time						Insurance Pays			
Estimated Anesthesia Time						Patient Pays			
Anesthesia Cost Grotto Pre-Authorized Fee						Balance			
			IVED FROM INSURAL SUBMITTING I	NCE, ETC	C. IS TO BE DI		D FROM BI	LL PRIOR TO	
Grotto Representative			-	Dentist's Signature					

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