Humanitarian Foundation – Grottoes International
ATTENDING DENTIST PRE-TREATMENT ESTIMATE

Sponsoring Grotto _____ **Special Need Condition** _____

Child's Name _____ **Sex** ☐Male ☐Female **Birthdate** _____

Address _____
Street City State Zip Code

Dentist's Name _____ **License No.** _____ **Tax ID No.** _____

Dentist's Address _____
Street City State Zip Code

Dentist Email _____ **Dentist Phone** _____

If this is a prosthesis, is this the initial placement? Yes☐ No☐

If No, Reason for replacement _____ **Date of prior placement** _____

PLEASE ATTACH PRETREATMENT PLAN

IF THIS CASE REQUIRES ANESTHESIA, PLEASE LIST THE FOLLOWING ESTIMATED COST FOR PREAUTHROIZATION

Provider _____
Provider Tax ID _____
Provider Email _____
Provider Phone _____
Estimated Anesthesia Time _____
Anesthesia Cost _____
Date of Treatment _____
HF Pays _____

Total Dentist Fee _____
Insurance Pays _____
HF Pays _____
Patient Pays _____
Balance _____

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

If you are a Medicaid provider, you cannot accept HF funds for a patient who is using their Medicaid benefit for that visit. Doing so is considered "Balance Billing" and is a violation of your provider agreement.

Grotto Rep Signature _____ **Dentist's Signature** _____

Return to Grotto Rep for signature, he will submit the paperwork to the Humanitarian Foundation Office for processing
Signatures Required