Georgia Transplant Foundation

Enriching Lives Everyday

Provider Agreement Form

I have read the Provider Information Sheet and understand my responsibilities. I have reviewed the attached fee schedule and agree to provide services to the following transplant candidate/recipient _____ for the amount listed on the treatment plan and in accordance to the GTF fee schedule or my routine cost, which ever cost is less.

I understand that the Dental Assistance Program's purpose is to expedite transplant readiness and will work to complete the dental procedures needed within 90 days, if possible. **I also understand that no treatment will be paid without prior approval by GTF.**

_____

Signature

_____

Fax Email

_____

Name

_____

Address

_____

City State Zip code

_____

Phone Fax

_____

Billing Manager - to handle billing and payment

Give this signed form and treatment plan **to the patient** to submit to their transplant social worker/coordinator who will then send to GTF along with their application.