Georgia Transplant Foundation
Enriching Lives Everyday

Dental Assistance Program
Provider Information Sheet

The Georgia Transplant Foundation (GTF) developed the Dental Assistance Program to address the needs of pre-transplant patients needing dental clearance to get listed for an organ transplant and post-transplant patients who have significant sources of infection.

1 – Pre-transplant dental assistance: Chronically ill patients, often living on a fixed income, cannot afford extra dental costs, yet they must be cleared from a dental perspective to be eligible for transplant. In order to receive dental clearance for transplant, a patient needs to be **clear of infection. Thus, the goal of any dental work provided by GTF is to clear infection, not necessarily to complete a full scope of potential dental needs.**

2 – Post-transplant dental assistance: GTF can assist post-transplant patients if the transplant center has documented a serious health risk (such as risk of infection) due to needed dental treatment. **The goal of any dental work provided by GTF is to clear infection, not necessarily to complete a full scope of potential dental needs.**

GTF has developed a fee schedule of covered procedures. We ask that you review this schedule and consider providing dental services to this client based on the attached fee schedule and reimbursement process. As GTF supports members of the transplant community in receiving quality affordable dental care, we ask that each service provider agree to charge the lower amount of either your routine fee or the fees on the attached schedule.

How the Program Works:

1. The **patient is responsible** for the cost of their initial visit with you.
2. Review the attached fee schedule.
3. If in agreement to accept payment from GTF at the fee schedule pricing, sign the attached agreement and **give it to the patient** to submit with GTF request for payment.
4. **Provide the patient** with a written treatment plan for all dental care needed.
5. If GTF approves the patient's application, GTF will fax or email dentist an approval letter for payment.
6. Dentist can then schedule the patient for dental treatment, which should be completed within 90 days.
7. Dental office will fax GTF a bill when **ALL treatment** is completed.
8. GTF will pay invoice to dentist, according to previously agreed fee schedule, within 10 business days.
9. No "add-on" treatment or follow-up treatment will be covered by GTF.
10. **No treatment will be paid without prior approval by GTF.**
11. Future dental needs are the responsibility of the patient and there is NO further responsibility from GTF.

Thank you for working with the Georgia Transplant Foundation and this patient to meet their dental requirements to be listed for a transplant. If you have any questions, please feel free to contact Rebekah Moshiri, Director of Patient Services, at 678-514-1179 or rmoshiri@gatransplant.org.

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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 with the GTF fee schedule or my routine cost, whichever 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 Date

_____

Dental Practice Name Practice Email Address

_____

Address

_____

City State Zip code

_____

Phone Fax

_____

Billing Manager - to handle billing and payment Email Address

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