

Ryan White Enrollment Application - Secondary Dental Services

Secondary Dental serves individuals with medical insurance but no dental insurance.

Individuals with no medical insurance should be enrolled in Ryan White Primary Care using form RW-1.

Clients will be registered only with the submission of this fully completed form and required supporting documentation.

PRINT

Last Name		First Name		MI	Social Security #	Mother's Maiden Name	
Date of Birth	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> MTF <input type="checkbox"/> FTM		Housing Status <input type="checkbox"/> Rent; <input type="checkbox"/> Own; <input type="checkbox"/> Rent room; <input type="checkbox"/> Live with family/ friends; <input type="checkbox"/> Substance Abuse Treatment Facility; <input type="checkbox"/> Assisted Living Facility; <input type="checkbox"/> Homeless				
Hispanic? <input type="checkbox"/> Yes; <input type="checkbox"/> No	Race: <input type="checkbox"/> White; <input type="checkbox"/> Black; <input type="checkbox"/> Asian; <input type="checkbox"/> American Indian/Native Alaskan; <input type="checkbox"/> Pacific Islander; Other: _____						
Home Address					City		
ZIP	County	Phone # Include Area Code		Gross monthly income \$		Household Size	
HIV/AIDS Status: <input type="checkbox"/> HIV positive, disease stage unknown; <input type="checkbox"/> HIV positive, asymptomatic; <input type="checkbox"/> HIV positive symptomatic, not AIDS; <input type="checkbox"/> HIV positive, disabling; <input type="checkbox"/> CDC-Defined AIDS; <input type="checkbox"/> Disabling AIDS						Year Status Effective	
HIV/AIDS status documentation: <input type="checkbox"/> Letter of Diagnosis; <input type="checkbox"/> Medical Record; <input type="checkbox"/> Lab Results							

1. Other Coverage/Insurance

a. Does client currently have Medi-Cal (Denti-Cal) coverage or dental insurance? Yes No (If "No" go to 1d)

b. If 1a is "Yes", Name of insurer: _____ Exp: _____

Member # _____

Copy both sides of the insurance card and retain with this application.

c. If 1a is "Yes" is this procedure covered by Denti-Cal or insurance? Yes No

If 1c is "Yes" STOP; the individual is not eligible for Secondary Dental for this procedure.

If 1c is "No", **attach the denial notice from the insurance carrier** (not needed for Denti-Cal).

d. Medical insurer/coverage _____

Member # _____ End Date _____

Copy both sides of the insurance card and retain with this application.

2. Eligibility (The following are program requirements; indicate completion by checkmark prior to faxing this form to UnitedHealthcare.)

Response to 1a is "No" and 1d is completed or 1a is "Yes" and 1c is "No".

HIV/AIDS status documentation has been provided and a copy is retained with this application.

Applicant has signed the ARIES Client Consent Form and a copy is retained with this application.

Applicant has provided his/her insurance card and a copy is retained with this application.

Applicant has provided a denial letter and a copy is retained with this application.

All information on this form is accurate to the best of my knowledge

Client Signature: _____ Date: _____

Staff completing this form: _____

Name/Title

Agency/Clinic

(_____) Phone Number

Submit this completed application and denial notice (if applicable) to UnitedHealthcare via fax number (855) 394-7927