



CarePoint Anesthesia

**8301 E Prentice Avenue, Suite 215
Greenwood Village, CO 80111
Phone (720) 606-4220
Fax (720) 606-4221
info@carepointanesthesia.com
www.carepointanesthesia.com**

Patient Insurance Guide

CarePoint Anesthesia Group is a fee-for-service practice and currently **out of network** with all private insurance companies. CarePoint does not manage insurance claims. However, you are welcome to submit your own independent reimbursement claim.

If you choose to pursue a claim, simply call your insurance company to determine if your plan has out of network benefits for office based anesthesia (OBA). Anesthesia could be covered under either medical or dental insurance, so we recommend calling both to find out details.

RECOMMENDED QUESTIONS FOR YOUR INSURANCE COMPANY:

- 1) Does your plan have *out of network* benefits for the procedure codes below?**
 - Medical CPT Code **00170** Anesthesia for Intraoral Procedures
 - Dental CDT Code **D9223** Deep sedation/general anesthesia

If there is coverage:

- 2) Is a prior authorization required? Does it need to be submitted and approved prior to the appointment? *Remember, a prior authorization is not a guarantee of payment.***
- 3) What forms, information and documentation are required for a prior authorization or claim?**
- 4) What conditions of medical necessity are required for coverage (cognitive/emotional condition, treatment result of accident)?**

If you have coverage, please complete and return the policy information section on page 2 of this form so that we can provide you with a claim form and letter of medical necessity. You may contact our office with questions at (720) 606-4220.

Please note: We also recommend obtaining the treatment plan and a letter of medical necessity from your dental office to submit with your anesthesia claim



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PRIVATE INSURANCE INFORMATION FORM

APPOINTMENT DATE: _____

PATIENT INFORMATION:



PATIENT NAME: _____ DOB: _____ SEX: M [] F []

RESPONSIBLE PARTY: _____ RELATIONSHIP: _____

TEL/CELL: _____ EMAIL: _____

MAILING ADDRESS: _____

PRIMARY INSURANCE: Dental [] Medical []



SUBSCRIBER NAME: _____

SUBSCRIBER ID or SSN: _____ DOB: _____

EMPLOYER: _____ GROUP#: _____

INSURANCE NAME: _____ TEL: _____

ADDRESS: _____

(If applicable) **SECONDARY INSURANCE:** Dental [] Medical [] Medicaid []



SUBSCRIBER NAME: _____

SUBSCRIBER ID or SSN: _____ DOB: _____

EMPLOYER: _____ GROUP#: _____

INSURANCE NAME: _____ TEL: _____

ADDRESS: _____

NOTES: _____

I authorize the release of any medical or other information necessary to process this claim.

Signature _____

Date _____