PRIVATE 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). The anesthesia services could be covered under either medical or dental insurance, so we recommend you calling both to find out your coverage benefits.

RECOMMENDED QUESTIONS TO ASK YOUR INSURANCE COMPANY:

1. Does your plan have an *out-of-network* benefits for the procedure codes listed below?
    a. Medical CPT Code "00170" – Anesthesia Procedure in mouth
    b. Dental CDT Code "D9222" – General Anesthesia, first 15 minutes
    c. Dental CDT Code "D9223" – General Anesthesia, each 15 minutes increments

2. If there is coverage:
    a. Is a prior authorization required? Does it need to be submitted and approved prior to the appointment? *Remember, a prior authorization does not a guarantee payment.*
    b. What forms, information, and documentation are required for a prior authorization or claim?
    c. What conditions of medical necessity are required for coverage (cognitive/emotional condition, treatment result of accident)?
    d. Please provide CarePoint Anesthesia a copy of the "Approved"' Pre-Determination letter from your insurance company.

If you have coverage, please complete and return the Private Insurance Information form on page 2, so that we can provide you with a reimbursement claim form. Upon request, we can submit your reimbursement claim form on your behalf. Please contact our office at 720-606-4220, should you have any questions.

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

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CarePoint
ANESTHESIA GROUP
A COMFORTABLE WAY TO A HEALTHY SMILE

REIMBURSEMENT CLAIM REQUEST
Insurance Information

Scheduled Appointment Date: _____

PATIENT INFORMATION:

NAME: _____ DOB: _____ GENDER: M [ ] F [ ]

RESPONSIBLE PARTY: _____ RELATIONSHIP: _____

TEL/CELL: _____ EMAIL: _____

MAILING ADDRESS: _____

_____

PRIMARY INSURANCE: **[ ] DENTAL [ ] MEDICAL [ ] COLORADO MEDICAID**

SUBSCRIBER NAME: _____ DOB: _____

MEMBER ID# or SSN: _____ GROUP #: _____

INSURANCE NAME: _____ TEL: _____

INSURANCE CLAIMS ADDRESS: _____

_____

SECONDARY INSURANCE: **[ ] DENTAL [ ] MEDICAL [ ] COLORADO MEDICAID**

SUBSCRIBER NAME: _____ DOB: _____

MEMBER ID# or SSN: _____ GROUP #: _____

INSURANCE NAME: _____ TEL: _____

INSURANCE CLAIMS ADDRESS: _____

_____

I, the undersigned, do hereby authorize the release of any medical or other information necessary to process this reimbursement claim.

POLICY HOLDER SIGNATURE: _____ **Date**: _____

Notes: _____

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