OMB Number: 2900-0335
Estimated burden: 20 min.
Expiration Date: 2/28/2007

NOTE All entries should be typewritten. If ballpoint pen is used, apply heavy pressure.

Department of Veterans Affairs

DENTAL RECORD AUTHORIZATION AND INVOICE FOR OUTPATIENT SERVICES

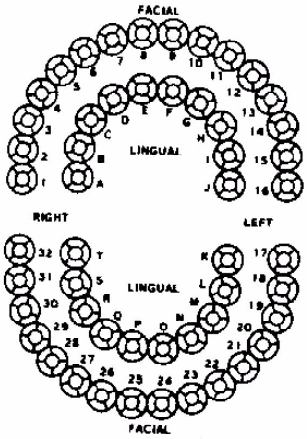
Paperwork Reduction Act: This data collection is in accordance with the clearance requirements of 5 CFR Part 1320. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 20 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form. This data is collected to authorize treatment, list the dental needs and serve as an invoice for treatment provided. Response is voluntary and failure to respond will have no impact on any benefits to which you may be entitled.

1. ISSUING OFFICE: Department of Veterans Affairs

FEE DENTIST: EXAMINATION AUTHORIZATION does NOT allow for proceeding beyond diagnoses and treatment plan. Complete all applicable items 2 through 13 and return (with X-rays) for TREATMENT AUTHORIZATION. Acceptance of an authorized treatment case constitutes a contract to provide the authorized services for the approved fees, as payment in full. The patient must not be requested to pay additional fees for those services. PLEASE REFER TO ENCLOSED VA FORMS 10-2570b or 10-2570c for specific procedural instructions.

2. NAME. ADDRESS AND ZIP CODE OF FEE DENTIST	3. ARE YOU NOW ON ACTIVE MILITARY DUTY YES ☐ NO ☐	4. SSN OR IRS GROUP NUMBER
9. DESCRIPTION OF SERVICE		4A. LICENSE NUMBER
2A. FEE DENTIST'S TELEPHONE	5. SIGNATURE OF FEE DENTIST	

6. "X" OUT MISSING TEETH



ENTER ONLY ONE TOOTH NUMBER, ONE PROCEDURE, ONE DATE OF SERVICE AND ONE FEE PER LINE

7. TOOTH NUMBER	8. SURFACES (MO, DO, MOD, etc.)	9. DESCRIPTION OF SERVICE (List specific treatment recommendations in this column & indicate your usual & customery fee in column 12)	10. DATE SERVICE PERFORMED	11. CODE NO.	12. USUAL & CUSTOMARY FEE	14. FEES APPROVED BY VA
		X-RAYS (Type & No.)				
		EXAMINATION (Indicate date)				

13. REMARKS: Include significant periodontal disease, soft tissue lesions, presence and serviceability of existing prostheses, pathogenicity of impacted teeth and statement concerning teeth extracted while in service. Attach additional sheet if necessary.

NOTICE: Acceptance of this authorization and providing of such services or treatment subjects you, the provider of care, to the provisions of Public Law 93-579, the Privacy Act of 1974, to the extent of the records of the treatment of this veteran. VA pertinent rules and regulations implementing this law are available on request at any VA facility.

15. FISCAL SYMBOL	16. OB. NO. AND D.S.	17. VA REGULATION
36 _____ 0160.001		
18. AUTHORIZATION FOR: X-RAYS AND: **EXAMINATION**		**$**

MEDICAL ADJUNCT CERTIFI CATION

21. DENTAL TREATMENT **IS** ☐ **IS NOT** ☐ NECESSARY AS ADJUNCT TO MEDICAL DISABILITY OF:

19. EXPIRATION DATE	20. AUTHORIZING SIGNATURE AND DATE	
24. FISCAL SYMBOL	25. OB. NO. AND D.S.	26. VA REGULATION
36 _____ 0160.001		

22. CERTIFYING SIGNATURE AND DATE

27. AUTHORIZATION FOR: **TREATMENT** **$**

DENTAL REVIEW/ APPROVAL

23. SERVICES NOT LINED OUT IN ITEM 9 ARE APPROVED

SIGNATURE OF CHIEF, DENTAL SERVICE OR DESIGNEE | DATE

28. EXPIRATION DATE	29. AUTHORIZING SIGNATURE AND DATE	
30. TOTAL AMOUNT AUTHORIZED		**$**

31. PRINT OR TYPE BENEFICIARY'S NAME, IDENTIFICATION NUMBER, CURRENT ADDRESS, ZIP CODE, AREA CODE AND TELEPHONE NUMBER

32. THE SERVICES AND FEES LISTED ARE APPROVED EXCEPT:

33. SIGNATURE OF APPROVING OFFICIAL	33A. DATE

FOR FISCAL USE ONLY

34. APPROVED	35. VOUCHER AUDIT	36. DATE
$		

STATION NUMBER	T/C & S/C	C P F	LIQ. AMT. $	1ST S/A $	DATE
PAT. NUMBER				2ND S/A $	INITIALS