Nevada Office of HIV/AIDS
Ryan White Part B Program (RWPB)
Dental Insurance Enrollment Form

Enrollment Process:
Completed Dental Insurance Enrollment Forms (19-08) must be uploaded to CAREWARE as part of the Universal Ryan White Application process (Please refer to the RWPB Primer 19-08A for details.)
• Clients enrolled **by** the 20th of the month will have a start date of the first of the following month.
• Clients enrolled **after** the 20th of the month will have a start date of the first of the second month following.
- For example: Client enrolled on January 20th the client's start date will be February 1st;
- Client enrolled on January 21st; the client's start date will be March 1st.

• Enrolled clients will receive their dental insurance cards via mail. If homeless, clients will need to contact Liberty Dental at (888) 401-1128 (8:00 am - 5:00 pm PT) to coordinate other ways to access the dental benefits.

Emergency Dental:
If emergency dental services are needed, as defined by the American Dental Association, be sure to check the Emergency Dental Request box on the form. ALL Emergency requests must be entered into the Liberty Dental Portal within two (2) business days. The start date for Emergency Dental will be the 1st of the month the service was requested. Please note that RWPB is the payer of last resort, and any other dental insurances will be billed first.

This form is part of the Eligibility Packet and must be uploaded into CAREWare.

CONTACT INFORMATION			
Current Ryan White Eligibility	**Start Date:**		**End Date:**
Eligibility Specialist Name:			**Direct Phone Number:**
Client Legal Last Name:	**Client Legal First Name:**		**Gender:**
URN:		**Emergency Dental Request (see above note):** ☐ Yes	
Date of Birth:		**Phone Number:**	
Language Preference: ☐ English ☐ Spanish ☐ Other: ______		**SSN or TIN*:**	
Home Address:	**City:**	**State:**	**Zip:**
Mailing Address** *(if different than home):*	**City:**	**State:**	**Zip:**

***SSN information is not used for eligibility. It is used to verify Medicaid or other health insurance information.**
*****Insurance information will be mailed to the listed mailing address.***

Please check all boxes below showing that you understand and agree to the following program requirements:

☐ I understand that in order to receive dental services, I will complete my annual certification and re-certification in the time frame established by the Ryan White Program in order to remain eligible for dental services.

☐ I understand that in order to receive dental services, I must have one dental prevention service every six months.

☐ I understand that failure to receive one dental prevention service every six months may lead to discontinuation of dental services.

☐ I fully understand that by completing this form, I am divulging personal information that will be used to assist me with benefits associated with the Nevada Medication Assistance Program.

☐ I understand this information will be kept confidential but will be used by staff to review my eligibility for this program.

Client Signature: ______________________ Date: ______________________