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

Enrollment Process:

Completed dental insurance enrollment forms must be uploaded by the lead case manager to https://dpbhsftp.nv.gov/EFTClient/Account/Login.htm and a notification sent to NVDental@health.nv.gov.
(Please refer to the **Ryan White Part B Primer 19-08A** for details.)

- Forms submitted **by** the 20th of the month will have a start date of the first (1st) of the following month.
- Forms submitted **after** the 20th of the month will have a start date of the first (1st) of the second month following.
  - For example: Forms submitted by January 20th will have a start date of February 1st; forms submitted after January 20th will have a start date of March 1st.
- Enrolled clients will receive their dental insurance cards via US mail.

Emergency Dental:
If emergency dental services are needed (as defined by this link https://medical-dictionary.thefreedictionary.com/dental+emergency), be sure to check the Emergency Dental Request box on the form below and type **"Emergency Dental Insurance Request"** in the subject line of the email. Emergency requests will be addressed within two (2) business days. 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:**	
Liberty Dental Eligibility	**Start Date:**	**End Date:**	
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 (1) dental prevention service every six (6) months.

☐ I understand that failure to receive one (1) dental prevention service every six (6) 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 Ryan White Part B Program.

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

☐ I fully understand that by singing this form, it is my responsibility to ensure any and all procedures are covered prior to procedure being completed or I may be liable for all cost associated with uncovered procedure.

☐ I fully understand that by singing this form, I have the right to request a prior approval letter for any and all procedures to ensure coverage.

Client Signature: Date: