TREATMENT VALUE FORM

There are two reasons we need you to fill out the Treatment Value Form:

1) Filling out and returning the Treatment Value Form to your referral coordinator will help us estimate the total value of dental care as well as the types of services being donated by dentists across Ohio.

2) At the end of each calendar year, you will receive information from us acknowledging your contribution to the program. This is subject to you proving the information to us as each case is completed.

How to complete the Treatment Value Form:

1. Fill in the patient's name, your name, the date treatment was completed and check if it was either donated care (Donated Dental Services component) or discounted care (Dentistry For All component).

2. Volunteer hours should reflect the estimated number of hours you and your staff spent providing services to the OPTIONS patient.

3. Determine the amount of donated or discounted serves you provided the OPTIONS patient using the formula provided. In other words, tell us how much the patient saved by being an OPTIONS patient at your office. Do not include in your 'usual fee' the amount you pay for any lab work. That amount will be reflected in the reports completed by the labs.

4. In the next section, please indicate how many of the procedures listed were performed for the OPTIONS patient.

5. Please fill out the experience evaluation at the bottom of the page. Feel free to include an additional sheet of paper with comments, or call with specific suggestions or concerns.

6. Evaluation forms should be returned back to your referral coordinator.

If you need assistance filling out the form, please call your regional referral coordinator at (888) 765-6789.

Treatment Value Form

Please use this form to document the type and value of treatment you have voluntarily provided through the OPTIONS program. After you have completed all the treatment needed by the patient, please complete and return the form to Dental OPTIONS at: Fax: (614) 564-2421

Patient _____ Dentist _____

Date Treatment Completed _____ Type Donated _____ Discounted _____

Volunteer Hours (approximate): Dentist _____ Assistant _____ Hygienist _____ Other _____

Total Value of Donated or Discounted Services Provided*: **$**_____

***Formula: Your usual fees ($_____) minus Lab Fees ($_____) minus Amount Patient paid (if any) ($_____) equals Total Value of Donated or Discounted Services Provided ($_____)**

****Value of lab services is provided by the dental lab**

Please indicate the number of completed procedures. For example, a full upper and lower denture should be recorded as "2 Full Dentures".

_____Examination	_____Restorations	_____Routine Extraction
_____X-rays	_____Crown & Bridge	_____Other Surgical Procedure
_____Prophy	_____Stainless Steel Crown	_____Partial Denture
_____Scaling/Root Planning	_____Orthodontic Treatment	_____Full Denture
_____Fluoride Treatment	_____Space Maintainer	_____Denture Reline
_____Sealant	_____Endodontic Treatment	_____Other _____

Please tell us how you felt about your experience with OPTIONS!

1. Was the method by which the patient was referred and the follow-up on their progress acceptable?
   _____Yes _____No
2. Should the referral process be changed, and if so, how? _____Yes _____No
   If yes, how?_____
3. Were you provided sufficient information about the patient? _____Yes _____No
   If no, what additional information would have been helpful?_____
4. Did you have any problems treating the patient referred to you? ____Yes _____No
   If yes, what problems did you have?_____
5. Describe what you like and don't like about the program and provide suggestions for improving it.
   _____
   _____
   _____