TEXAS Health and Human Services

**Form 2463**
December 2010

# Emergency Dental Services

| CMS Provider No. | Nursing Facility | Address | Fax No. |
|---|---|---|---|
| | | | |

| Resident's Last Name | Resident's First Name | Resident's Medicaid No. | Area Code and Telephone No. |
|---|---|---|---|
| | | | |

| Line | Date of Service | ADA Code | Procedure Provided (include tooth number) | Number of Units | Unit Base Rate | Line Item Total |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | | | | | | |
| 8 | | | | | | |
| 9 | | | | | | |
| 10 | | | | | | |
| 11 | | | | | | |
| 12 | | | | | | |
| 13 | | | | | | |
| 14 | | | | | | |
| 15 | | | | | | |
| 16 | | | | | | |
| 17 | | | | | | |
| | | | | | **Claim Total** | |

I certify that this information is true, accurate and complete to the best of my knowledge.

I understand that claiming for services not actually provided constitutes fraud.

Administrator Signature

Date