



Professional Interpreter Service

**Bill To: DentaQuest - Cardinal Cares Smiles
PO Box 2906
Milwaukee, WI 53201-2906
Fax: 262-834-3589**

D9990 (Certified translation or sign-language services – per visit (up to \$65 per hour – 15 minute increments).

In order to be reimbursed for D9990, the provider must submit the following with the ADA claim for pre-payment review:

- ▶ Cardinal Cares Smiles (CCS) Professional Interpreter Service Form documenting the services provided by and paid to an interpreter that is proficient in the specific language and that holds a Virginia business license allowing a fee for their service. CCS Professional Interpreter Service Invoice Form must be completed and submitted to DentaQuest within 365 days from the date the interpreter service is utilized.
- ▶ A copy of the paid invoice/receipt to DentaQuest to include the following information:
 - Date and Time of Interpreter service (including beginning and ending time).
 - Patient Name and Medicaid ID number
 - Interpreter name, address, telephone number, language used, duration of service and interpreter’s charge for the service.
 - If the interpreter is not listed on the DMAS Interpreter Resource list, the provider must attach a copy of the professional interpreter’s business license with the invoice.
 - The patient’s chart must document that the patient needed and received interpreter services on a specific date. If ongoing interpreter services are required, the provider must include an annual assessment and attestation in the patient’s chart confirming need. Payment for that service acknowledges DentaQuest’s ability to audit the use of the service at any time.

To be eligible for reimbursement, services must be rendered in conjunction with an eligible CCS dental service and the ADA claim for these services must be reflected in DentaQuest’s claim system.

Note: Charges incurred for a missed or broken appointment are not eligible for reimbursement.

TO PROTECT PHI, THIS FORM MUST ONLY CONTAIN INFORMATION FOR ONE MEMBER.

Date of Service	Start Time	End Time	Member Name <i>(One member per form)</i>	Member ID	Professional Interpreter Service Name	Language Used	Total \$ Amount
TOTAL INVOICE:							

I certify that the patient identified with this invoice by this practice need interpreter services to communicate in order to complete care.

Invoice Date: _____

Provider Name: _____
(Please Print)

Provider’s Signature: _____

Thank You for Your Participation in the Cardinal Care Smiles Program.