



### Professional Interpreter Service Invoice

**Bill To:** DentaQuest - Smiles For Children  
 7400 Beaufont Springs Drive  
 Suite 300  
 Richmond, VA 23225  
 Attn: Kristen Gilliam  
 Fax: 804-327-6831

**Send Payment To:** Name of Payee: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_

**Provider Name:** \_\_\_\_\_

**Provider's Signature:** \_\_\_\_\_

**Date of Invoice:** \_\_\_\_\_

**To be eligible for reimbursement:**

- ▶ A copy of the professional interpreter service's invoice or statement for each case being billed to DentaQuest must be included.
- ▶ Services must be rendered in conjunction with an eligible SFC dental service and the claim for these services must be reflected in DentaQuest's claims system.
- ▶ SFC Professional Interpreter Service Invoice Form must be completed and submitted to DentaQuest within 180 days from the date the interpreter service is utilized.

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

	Date of Service	Start Time	End Time	Member Name (Please include only one Member Name per Case)	Member ID	Professional Interpreter Service Name	Language Used	Total \$ Amount
Case 1								
Case 2								
Case 3								
Case 4								
Case 5								
Case 6								
Case 7								
Case 8								
Case 9								
Case 10								
<b>TOTAL INVOICE:</b>								

I certify that the patient(s) identified with this invoice by this practice need interpreter services to communicate in order to complete care.  
 Signed: \_\_\_\_\_

**Thank You for Your Participation in the Smiles For Children Program.**