

Effective Date

To the Parents of "Member Name"

Address

City State Zip

Re: The Children's Program

ID#: xxxxx

Dear Parent/Legal Guardian of "Member name"

The Children's Program provides basic dental services for uninsured 6-12 year-olds in Oregon. Your child _____ (member's name) has been selected to receive service from The Children's Program. The plan covers basic services up to \$500 at no charge to you.

All covered services up to \$500 provided by Dr _____ between now and _____ (term date), are provided at no charge to your family. Dental treatment for your child must be scheduled and completed within this time period. Covered services include, but are not limited to, exams, x-rays, cleanings, sealants, relief of pain, fillings and extractions. Any services that have been agreed to by you, the parent/legal guardian, that are not covered by The Children's Program or services received after your eligibility period will be your responsibility.

Please contact the following provider as soon as possible to schedule an appointment for your child. When you call for an appointment, please identify that you are with The Children's Program and provide the ID# xxxxx. Please bring a copy of this letter to your child's appointment.

Dentist Name: _____ Phone: _____

If your child is already a patient of record with a dentist other than the one listed above, please contact ODS customer service to see if your dentist participates in this program.

If your child is covered by any dental plan, they are not eligible for this program.

If you have any questions regarding the program feel free to contact your child's school or ODS customer service; English: (503) 265-2965 or (888) 217-2365; Spanish:(503) 265-2963 or (877) 299-9063.

Sincerely,

Dental Customer Service