Dental Claim Form

See reverse for instructions

1. ☐ Dentist's pre-treatment estimate
☐ Dentist's statement of actual services
Provider ID #

2. ☐ Medicaid Claim
☐ EPSDT
Prior Authorization #
Patient ID #

3. Carrier name and address

PATIENT COVERAGE INFORMATION

4. Patient name — first / m.i. / last

5. Relationship to employee — ☐self ☐child ☐spouse ☐other

6. Sex — m f

7. Patient birthdate — MM DD YYYY

8. If full time student — school / city

9. Employee/subscriber name and mailing address

10. Employee/subscriber dental plan I.D. number

11. Employee/subscriber birthdate — MM DD YYYY

12. Employer (company) name and address

13. Group number

14. Is patient covered by another dental plan — yes no
If yes, complete 15-a.
Is patient covered by a medical plan? yes no

15-a. Name and address of carrier(s)

15-b. Group no.(s)

16. Name and address of other employer(s)

17-a. Employee/subscriber name (if different from patient's)

17-b. Employee/subscriber dental plan I.D. number

17-c. Employee/subscriber birthdate — MM DD YYYY

18. Relationship to patient — ☐self ☐parent ☐spouse ☐other

19. **I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.**

> X
Signed (Patient* - see reverse) Date

20. **I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.**

> X
Signed (Employee/subscriber) Date

BILLING DENTIST

21. Name of Billing Dentist or Dental Entity

22. Address where payment should be remitted

23. City, State, Zip

24. Dentist Soc. Sec. or T.I.N. (see reverse**)

25. Dentist license no.

26. Dentist phone no.

27. First visit date current series

28. Place of treatment — Office | Hosp. | ECF | Other

29. Radiographs or models enclosed? — No | Yes | How many?

30. Is treatment result of occupational illness or injury? — No | Yes — If yes, enter brief description and dates

31. Is treatment result of auto accident? — No | Yes

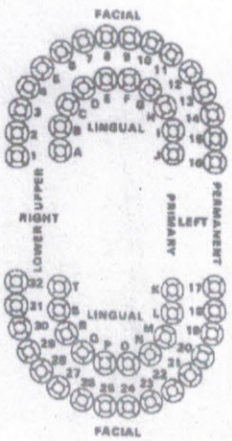
32. Other accident? — No | Yes

33. If prosthesis, is this initial placement? — No | Yes — (If no, reason for replacement)

34. Date of prior placement

35. Is treatment for orthodontics? — No | Yes — If service already commenced enter: Date appliances placed / Mos. treatment remaining

36. Identify missing teeth with "x"



37. Examination and treatment plan -List in order from tooth no. 1 through tooth no. 32 - Using charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year	Procedure number	Fee	For administrative use only

38. Remarks for unusual services

39. **I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.**

> _____
Signed (Treating Dentist) License Number Date

40. Address where treatment was performed
City State Zip

41. Total Fee Charged	
42. Payment by other plan	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	

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