

See reverse for instructions

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|---|--|---|---|--|--|---|--|---|---------------------------------|-------------------------------------|
| 1. <input type="checkbox"/> Dentist's pre-treatment estimate <input type="checkbox"/> Dentist's statement of actual services Provider ID # | | 2. <input type="checkbox"/> Medicaid Claim <input type="checkbox"/> EPSDT Prior Authorization # Patient ID # | | | 3. Carrier name and address | | | | | |
| PATIENT COVERAGE INFORMATION | 4. Patient name first _____ m.i. _____ last _____ | | 5. Relationship to employee <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse <input type="checkbox"/> 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 <input type="checkbox"/> self <input type="checkbox"/> parent <input type="checkbox"/> spouse <input type="checkbox"/> 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. | | | | | 20. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity. | | | | | |
| > Signed (Patient* - see reverse) _____ Date _____ | | | | | > Signed (Employee/subscriber) _____ Date _____ | | | | | |
| BILLING DENTIST | 21. Name of Billing Dentist or Dental Entity | | | | 30. Is treatment result of occupational illness or injury? | | No Yes | If yes, enter brief description and dates | | |
| | 22. Address where payment should be remitted | | | | 31. Is treatment result of auto accident? | | No Yes | | | |
| | 23. City, State, Zip | | | | 32. Other accident? | | No Yes | | | |
| | 24. Dentist Soc. Sec. or T.I.N. (see reverse**) | | 25. Dentist license no. | 26. Dentist phone no. | | 33. If prosthesis, is this initial placement? | | No Yes | (if no, reason for replacement) | 34. Date of prior placement |
| | 27. First visit date current series | 28. Place of treatment Office Hosp. ECF Other | | 29. Radiographs or models enclosed? | No Yes | How many? | 35. Is treatment for orthodontics? | | No Yes | If service already commenced enter: |
| Date | Date | Date | Date | Date | Date | Date | Date | Date | Date | |
| 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. | | | | | | For administrative use only | | |
| | | Tooth # or letter | Surface | Description of service (including x-rays, prophylaxis, materials used, etc.) | | Date service performed Mo. Day Year | | Procedure number | Fee | |
| | | | | | | | | | | |
| 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. | | | | | | | 41. Total Fee Charged | 42. Payment by other plan | | |
| > Signed (Treating Dentist) _____ License Number _____ Date _____ | | | | | | | Max. Allowable | | | |
| 40. Address where treatment was performed | | | | | | | Deductible | | | |
| City _____ State _____ Zip _____ | | | | | | | Carrier % | | | |
| | | | | | | | Carrier pays | | | |
| | | | | | | | Patient pays | | | |