

Policyholder

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|---|-----------------|-----------|
| 1. Policyholder SSN/ID# | 2. Birth Date | 3. Gender |
| 4. Policyholder Name (Last, First, M.I., Suffix) | | |
| 5. Policyholder Address | | |
| 6. Policyholder City, State, Zip | | |
| 7. Policyholder Employer | 8. Plan/Group # | |
| I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the named dentist or dental entity. | | |
| Signed: _____ | | Date: - - |

Patient

| | | |
|--|----------------|--------------------------------------|
| 9. Patient Name (Last, First, M.I., Suffix) | | 10. Gender |
| 11. Relationship to Policyholder | 12. Birth Date | 13. Student <input type="checkbox"/> |
| I have been informed of the treatment plan and associated fees. I agree to be responsible for charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or 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 by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. | | |
| Signed: _____ | | Date: - - |
| Parent or Guardian | | |

Insurance Information

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|---|--|--|---------------------|------------------|
| 14. Primary Insurance Company | | | | |
| 15. Primary Insurance Address, City, State, Zip | 16. Primary Insurance Payment | | | |
| 17. Transaction Type: <input type="checkbox"/> Statement of Service <input type="checkbox"/> Request for Predetermination/Preauthorization | | | | |
| Other Coverage | | | | |
| 18. Secondary Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: <input type="checkbox"/> Dental <input type="checkbox"/> Medical | 19. Name of Policyholder (Last, First, M.I., Suffix) | | | |
| 20. Relationship to Policyholder | 21. Birth Date | 22. Gender | 23. Covered SSN/ID# | 24. Plan/Group # |
| 25. Secondary Insurance Company | | 26. Predetermination/Preauthorization Number | | |
| 27. Secondary Insurance Address, City, State, Zip | | | | |

Ancillary Information

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|---|---------------------|----------------------|------------------------------|--------------------|
| 28. Place of Treatment (circle): | | Provider's Office | Hospital | ECF |
| 29. Number of enclosures (0 to 99): | Radiograph(s): | Oral Image(s): | Model(s): | Charting: |
| 30. Prosthesis Placed: <input type="checkbox"/> Initial Placement <input type="checkbox"/> Prior Placement | | | 31. Prior Placement Date - - | |
| 32. Treatment resulting from: <input type="checkbox"/> Occupational Injury/Illness <input type="checkbox"/> Auto Accident <input type="checkbox"/> Other Accident | | | 33. Accident Date - - | 34. Accident State |
| <input type="checkbox"/> 35. Treatment for Orthodontics | 36. Placed Date - - | 37. Months Remaining | | |

Provider Information

I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

Dentist Signature: _____ Date: - -

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|--|------------------------|------------------------------------|------------------------|
| 38. Treating Provider Name (Last, First, M.I., Suffix) | | | 39. Phone |
| 40. Treating Provider Address, City, State, Zip | | | 41. Taxonomy Code |
| 42. Provider NPI# (Type 1) | 43. License #/Other ID | 44. Provider Billing NPI# (Type 2) | 45. License #/Other ID |
| 46. Provider Billing Name (Last, First, M.I., Suffix) | | 47. Provider Billing SSN/TIN# | 48. Phone |
| 49. Provider Billing Address, City, State, Zip | | | |

Services

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|-----------------------------------|-----------------|--------------------|-------------------|----------------------|---|--------------------|---------------|---|---|----|----|----|----|----|---------------|----|---------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|--|
| 50. Check missing tooth number(s) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | |
| | A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R | S | T | | | | | | | | | | | | | |
| 51. Procedure Date | 52. Oral Cavity | 53. Tooth #/Letter | 54. Tooth Surface | 55. Diagnostic Codes | | 56. Procedure Code | 57. Treatment | | | | | | | | | | 58. Fee | | | | | | | | | | | | | | | | |
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| 59. Remarks | | | | | | | | | | | | | | | 60. Total Fee | | | | | | | | | | | | | | | | | | |