

ATTENDING DENTIST'S STATEMENT

Check one: <input type="checkbox"/> Dentist's pre-treatment estimate <input type="checkbox"/> Dentist's statement of actual services		Carrier name and address			
P A T I E N T C O V E R A G E I N F O R M A T I O N	1. Patient name first _____ m.i. _____ last _____	2. Relationship to employee <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse <input type="checkbox"/> other _____	3. Sex m _____ f _____	4. Patient birthdate MM ____ DD ____ YYYY ____	5. If full time student school _____ city _____
	6. Employee/subscriber name and mailing address	7. Employee/subscriber soc. sec. or I.D. number	8. Employee/subscriber birthdate MM ____ DD ____ YYYY ____	9. Employer (company) name and address	10. Group number
	11. Is patient covered by another dental plan? yes _____ no _____ if yes, complete 12-a. Is patient covered by a medical plan? yes _____ no _____	12-a. Name and address of carrier(s)	12-b. Group no.(s)	13. Name and address of other employer(s)	
	14-a. Employee/subscriber name (if different than patient's)	14-b. Employee/subscriber soc. sec. or I.D. number	14-c. Employee/subscriber birthdate MM ____ DD ____ YYYY ____	15. Relationship to patient <input type="checkbox"/> self <input type="checkbox"/> parent <input type="checkbox"/> spouse <input type="checkbox"/> other _____	

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

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

Signed (Patient, or parent if minor) _____ Date _____		Signed (insured person) _____ Date _____	
16. Name of Billing Dentist or Dental Entity		24. Is treatment result of occupational illness or injury?	No Yes
17. Address where payment should be remitted		25. Is treatment result of auto accident?	No Yes
City, State, Zip		26. Other accident?	No Yes
18. Dentist Soc. Sec. or T.I.N.	19. Dentist license no.	20. Dentist phone no.	27. If prosthesis, is this initial placement?
21. First visit date current series	22. Place of treatment Office Hosp. ECF Other	23. Radiographs or models enclosed No Yes How many?	28. Is treatment for orthodontics?
		(If no, reason for replacement)	28. Date of prior placement
		If services already commenced enter:	Date appliances placed: Mos. treatment remaining

Identify missing teeth with "x"	30. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Use charting system shown.						For administrative use only
	Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed	Procedure number	Fee	

31. Remarks for unusual services

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.				Total Fee Charged	
Signed (Treating Dentist) _____		License Number _____ NPI _____		Date _____	
				Max. Allowable	
				Deductible	
				Carrier %	
				Carrier pays	
				Patient pays	

See back of ID card for claim mailing address and customer service phone number.