Dental Claim Form

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

Provider ID #

2.
- ☐ Medicaid Claim
- ☐ EPSDT

Prior Authorization #
Patient ID #

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.

> Signed (Patient) ______ Date ______

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

> 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.

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?

	No	Yes	If yes, enter brief description and dates.
30. Is treatment result of occupational illness or injury?			
31. Is treatment result of auto accident?			
32. Other accident?			
33. If prosthesis, is this initial placement?			(If no, reason for replacement) — 34. Date of prior placement
35. Is treatment for orthodontics?			If service already commenced enter: Date appliances placed — Mos. treatment remaining

36. Identify missing teeth with "x"

FACIAL — 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 — A B C D E F G H I J — LINGUAL — UPPER — RIGHT — PRIMARY — LEFT — PERMANENT — LOWER — T S R Q P O N M L K — LINGUAL — 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 — FACIAL

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	
Patient pays	

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