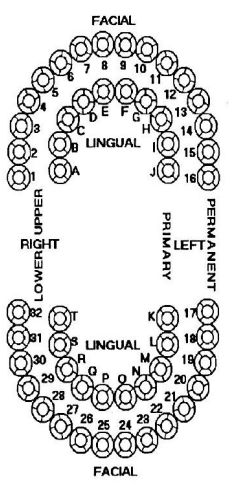


Dental Claim Form

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 _____ _____ _____						
P A T I E N T C O V E R A G E I N F O	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"/> child <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. _____ Signed (Patient or guardian) _____ 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 _____						
B I L L I N G D E N T I S T	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. _____		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 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.					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. _____ Signed (Treating Dentist) _____ License Number _____ Date _____								41. Total Fee Charged _____			
								42. Payment by other plan _____			
40. Address where treatment was performed _____ City _____ State _____ Zip _____								Max. Allowable _____			
								Deductible _____			
								Carrier % _____			
								Carrier pays _____			
								Patient pays _____			