

HEADER INFORMATION																																				
1. Type of Transaction (Check all applicable boxes) <input type="checkbox"/> Statement of Actual Services - OR - <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT/Title XIX																																				
2. Predetermination/Preauthorization Number					PRIMARY INSURED INFORMATION																															
PRIMARY PAYER INFORMATION																																				
3. Name, Address, City, State, Zip Code																																				
OTHER COVERAGE																																				
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)																																				
5. Insured Name (Last, First, Middle Initial, Suffix)																																				
6. Date of Birth (MM/DD/YYYY)		7. Gender <input type="checkbox"/> M <input type="checkbox"/> F		8. Insured Identifier (SSN or ID#)																																
9. Plan/Group Number		10. Relationship to Primary Insured (Check applicable box) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other																																		
11. Other Carrier Name, Address, City, State, Zip Code																																				
					12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code		13. Date of Birth (MM/DD/YYYY)			14. Gender <input type="checkbox"/> M <input type="checkbox"/> F		15. Insured Identifier (SSN or ID#)																								
					16. Plan/Group Number			17. Employer Name																												
PATIENT INFORMATION																																				
18. Relationship to Primary Insured (Check applicable box) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other								19. Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PTS																												
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																																				
21. Date of Birth (MM/DD/YYYY)		22. Gender <input type="checkbox"/> M <input type="checkbox"/> F		23. Patient ID/Account # (Assigned by Dentist)																																
RECORD OF SERVICES PROVIDED																																				
24. Procedure Date (MM/DD/YYYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description					31. Fee																									
1																																				
2																																				
3																																				
4																																				
5																																				
6																																				
7																																				
MISSING TEETH INFORMATION																																				
34. (Place an 'X' on each missing tooth)										Permanent										Primary										32. Other Fee(s)						
										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	
35. Remarks										32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee
										AUTHORIZATIONS										ANCILLARY CLAIM/TREATMENT INFORMATION																
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all 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. I acknowledge that I have read the applicable fraud notice on page 2. X _____ Patient/Guardian signature Date										38. Place of Treatment (Check applicable box) <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other					39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																					
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. X _____ Insured signature Date										40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)					41. Date Appliance Placed (MM/DD/YYYY)																					
48. Name, Address, City, State, Zip Code										42. Months of Treatment Remaining		43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)			44. Date Prior Placement (MM/DD/YYYY)																					
										45. Treatment Resulting from (Check applicable box) <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident										46. Date of Accident (MM/DD/YYYY)					47. Auto Accident State											
49. Provider ID										TREATING DENTIST AND TREATMENT LOCATION INFORMATION																										
										50. License Number										51. SSN or TIN																
52. Phone Number ()										53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures. I acknowledge that I have read the applicable fraud notice on page 2. X _____ Signed (Treating Dentist) Date					54. Provider ID					55. License Number																
56. Address, City, State, Zip Code										57. Phone Number ()					58. Treating Provider Speciality																					