

HEADER INFORMATION			
1. Type of Transaction (Mark all applicable boxes)			
<input type="checkbox"/> Statement of Actual Services	<input type="checkbox"/> Request for Predetermination/Preauthorization		
<input type="checkbox"/> EPSDT/Title XIX			
2. Predetermination/Preauthorization Number			
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION			
3. Company/Plan 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. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)			
6. Date of Birth (MM/DD/CCYY)	7. Gender <input type="checkbox"/> M <input type="checkbox"/> F	8. Policyholder/Subscriber ID (SSN or ID#)	
9. Plan/Group Number	10. Patient's Relationship to Person Named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other		
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code			

[illegible]

	24. Procedure Date (MM/DD/CCYY)	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								
8								
9								
10								

34. (Place an "X" on each missing tooth)		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	33. Total Fee(s)		
		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			
35. Remarks																														

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.

X _____
Patient/Guardian signature Date

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 _____
Subscriber signature Date

38. Place of Treatment <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="text"/> <input type="text"/> <input type="text"/>	
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/CCYY) <input type="text"/>	
42. Months of Treatment Remaining <input type="text"/>	43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)	44. Date of Prior Placement (MM/DD/CCYY) <input type="text"/>	
45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident			
46. Date of Accident (MM/DD/CCYY) <input type="text"/>		47. Auto Accident State <input type="text"/>	

48. Name, Address, City, State, Zip Code		
49. NPI	50. License Number	51. SSN or TIN
52. Phone Number () -	52A. Additional Provider ID	

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

X _____ Date _____

Signed (Treating Dentist)

54. NPI	55. License Number
56. Address, City, State, Zip Code	56A. Provider Specialty Code
57. Phone Number () -	58. Additional Provider ID