

Dental Claim Form

1. <input type="checkbox"/> Dentist's pre-treatment estimate <input type="checkbox"/> Dentist's statement of actual services Specialty _____	3. Carrier Name _____
2. <input type="checkbox"/> Medicaid Claim <input type="checkbox"/> EPSDT Prior Authorization # _____	4. Carrier Address _____ 5. City _____ 6. State _____ 7. Zip _____

PATIENT	8. Patient Name (Last, First, Middle) _____	9. Address _____	10. City _____	11. State _____
	12. Date of Birth (MM/DD/YYYY) / /	13. Patient ID # _____	14. Sex <input type="checkbox"/> M <input type="checkbox"/> F	15. Phone Number _____
	17. Relationship to Subscriber/Employee: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____		18. Employer/School Name _____ Address _____	

SUBSCRIBER / EMPLOYEE	19. Subs./Emp. ID#/SSN# _____	20. Employer Name _____	21. Group # _____	OTHER POLICIES	31. Is Patient covered by another plan <input type="checkbox"/> No (Skip 32-37) <input type="checkbox"/> Yes: <input type="checkbox"/> Dental or <input type="checkbox"/> Medical	32. Policy # _____		
	22. Subscriber/Employee Name (Last, First, Middle) _____				33. Other Subscriber's Name _____			
	23. Address _____		24. Phone Number _____		34. Date of Birth (MM/DD/YYYY) / /	35. Sex <input type="checkbox"/> M <input type="checkbox"/> F	36. Plan/Program Name _____	
	25. City _____		26. State _____		27. Zip Code _____	37. Employer/School Name _____ Address _____		
	28. Date of Birth (MM/DD/YYYY) / /		29. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other		30. Sex <input type="checkbox"/> M <input type="checkbox"/> F		38. Subscriber/Employee Status <input type="checkbox"/> Employed <input type="checkbox"/> Part-time status <input type="checkbox"/> Full-time Student <input type="checkbox"/> Part-time Student	
	39. 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 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. X _____ Signed (Patient/Guardian) _____ Date (MM/DD/YYYY) _____				40. Employer/School Name _____ Address _____			
					41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity. X _____ Signed (Employee/Subscriber) _____ Date (MM/DD/YYYY) _____			

BILLING DENTIST	42. Name of Billing Dentist or Dental Entity _____		43. Phone Number _____	44. Provider ID # _____	45. Dentist Soc. Sec. or T.I.N. _____
	46. Address _____		47. Dentist License # _____	48. First visit date of current series: _____	49. Place of treatment <input type="checkbox"/> Office <input type="checkbox"/> Hosp. <input type="checkbox"/> ECF <input type="checkbox"/> Other
	50. City _____	51. State _____	52. Zip Code _____	53. Radiographs or models enclosed? <input type="checkbox"/> Yes, How many? _____ <input type="checkbox"/> No	
	54. Is treatment for orthodontics? If service already commenced: _____ Date appliances placed _____ Total mos. of treatment remaining _____		55. If prosthesis (crown, bridge, dentures), is this initial replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, reason for replacement: _____ Date of prior placement: _____		
	56. Is treatment result of occupational illness or injury? <input type="checkbox"/> No <input type="checkbox"/> Yes Brief description and dates _____		57. Is treatment result of: <input type="checkbox"/> auto accident? <input type="checkbox"/> other accident? <input type="checkbox"/> neither Brief description and dates _____		

58. Diagnosis Code Index (optional)
 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____

59. Examination and treatment plans - List teeth in order												Admin. Use Only															
Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee																				
60. Identify all missing teeth with "X"																											
Permanent								Primary				Total Fee															
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	Payment by other plan
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	Max. Allowable
61. Remarks for unusual services _____												Deductible															
											Carrier %																
											Carrier Pays																
											Patient Pays																

62. 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. X _____ Signed (Treating Dentist) _____ License # _____ Date (MM/DD/YYYY) _____	63. Address where treatment was performed _____ 64. City _____ 65. State _____ 66. Zip Code _____
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