# Dental Claim Form

☐ Dentist's pre-treatment estimate  Specialty (see backside)
☐ Dentist's statement of actual services
☐ Medicaid Claim  Prior Authorization #
☐ EPSDT

**PATIENT**

| Patient Name (Last, First, Middle) | Address | City | State |
|---|---|---|---|
| | | | |

| Date of Birth (MM/DD/YYYY) | Patient ID # | Sex | Phone Number | Zip Code |
|---|---|---|---|---|
| / / | | ☐M ☐F | ( ) | |

Relationship to Subscriber/Employee:
☐Self ☐Spouse ☐Child ☐Other_____

Employer/School
Name_____ Address_____

**SUBSCRIBER / EMPLOYEE**

| Subs./Emp. ID#/SSN# | Employer Name | Group # |
|---|---|---|
| | | |

Subscriber/Employee Name (Last, First, Middle)

| Address | Phone Number | City | State | Zip Code |
|---|---|---|---|---|
| | ( ) | | | |

| Date of Birth (MM/DD/YYYY) | Marital Status | Sex |
|---|---|---|
| / / | ☐Married ☐Single ☐Other | ☐M ☐F |

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)

**OTHER POLICIES**

| Is Patient covered by another plan | Policy # |
|---|---|
| ☐No (Skip 32–37) ☐Yes: ☐Dental or ☐ Medical | |

Other Subscriber's Name

| Date of Birth (MM/DD/YYYY) | Sex | Plan/Program Name |
|---|---|---|
| / / | ☐M ☐F | |

Employer/School
Name_____ Address_____

Subscriber/Employee Status
☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student

Employer/School
Name_____ Address_____

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**

| Name of Billing Dentist or Dental Entity | Phone Number | Provider ID # | Dentist Soc. Sec. or T.I.N. |
|---|---|---|---|
| | ( ) | | |

| Address | Dentist License # | First visit date of current series: | Place of treatment |
|---|---|---|---|
| | | | ☐Office ☐Hosp. ☐ECF ☐Other |

| City | State | Zip Code | Radiographs or models enclosed? | Is treatment for orthodontics? ☐Yes ☐No |
|---|---|---|---|---|
| | | | ☐Yes, How many?_____ ☐No | If service already commenced: |

If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No
If no, reason for replacement: _____
Date of prior placement: _____
Date appliances placed _____ Total mos. of treatment remaining _____

Is treatment result of occupational illness or injury? ☐No ☐ Yes
Brief description and dates_____

Is treatment result of: ☐auto accident? ☐other accident? ☐neither
Brief description and dates_____

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

Examination and treatment plans – List teeth in order

| Date (MM/DD/YYYY) | Tooth | Surface | Diagnosis Index # | Procedure Code | Qty | Description | Fee |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
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| | | | | | | | |

Admin. Use Only

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 | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | Deductible | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | Carrier % | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | Carrier pays | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | Patient pays | |

Remarks for unusual services

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)

Address where treatment was performed

| City | State | Zip Code |
|---|---|---|
| | | |