

Policyholder

1. Policyholder SSN/ID#	2. Birth Date	3. Gender
4. Policyholder Name (Last, First, M.I., Suffix)		
5. Policyholder Address		
6. Policyholder City, State, Zip		
7. Policyholder Employer	8. Plan/Group #	
I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the named dentist or dental entity.		
Signed: _____		Date: ____ - ____ - ____

Patient

9. Patient Name (Last, First, M.I., Suffix)		10. Gender
11. Relationship to Policyholder	12. Birth Date	13. Student ☐
I have been informed of the treatment plan and associated fees. I agree to be responsible for 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.		
Signed: _____ Parent or Guardian		Date: ____ - ____ - ____

Insurance Information

14. Primary Insurance Company	
15. Primary Insurance Address, City, State, Zip	16. Primary Insurance Payment
17. Transaction Type: ☐ Statement of Service ☐ Request for Predetermination/Preauthorization	
Other Coverage	
18. Secondary Coverage: ☐ Yes ☐ No If Yes: ☐ Dental ☐ Medical	19. Name of Policyholder (Last, First, M.I., Suffix)
20. Relationship to Policyholder	21. Birth Date
22. Gender	23. Covered SSN/ID#
24. Plan/Group #	25. Secondary Insurance Company
26. Predetermination/Preauthorization Number	
27. Secondary Insurance Address, City, State, Zip	

Ancillary Information

28. Place of Treatment (circle):	Provider's Office	Hospital	ECF
29. Number of enclosures (0 to 99):	Radiograph(s):	Oral Image(s):	Model(s):
30. Prosthesis Placed: ☐ Initial Placement ☐ Prior Placement	31. Prior Placement Date ____ - ____ - ____		
32. Treatment resulting from: ☐ Occupational Injury/Illness ☐ Auto Accident ☐ Other Accident	33. Accident Date ____ - ____ - ____	34. Accident State	
☐ 35. Treatment for Orthodontics	36. Placed Date ____ - ____ - ____	37. Months Remaining	

Provider Information

I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.			
Dentist Signature: _____			Date: ____ - ____ - ____
38. Treating Provider Name (Last, First, M.I., Suffix)			39. Phone
40. Treating Provider Address, City, State, Zip			41. Taxonomy Code
42. Provider NPI# (Type 1)	43. License #/Other ID	44. Provider Billing NPI# (Type 2)	45. License #/Other ID
46. Provider Billing Name (Last, First, M.I., Suffix)		47. Provider Billing SSN/TIN#	48. Phone
49. Provider Billing Address, City, State, Zip			

Services

50. Check missing tooth number(s)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T												
51. Procedure Date	52. Oral Cavity	53. Tooth #/Letter	54. Tooth Surface	55. Diagnostic Codes		56. Procedure Code	57. Treatment		58. Fee																							
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59. Remarks																												60. Total Fee				