

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

<b>PATIENT</b>	8. Patient First Name Initial Patient Last Name			9. Address			10. City		11. State	
	12. Date of Birth (MM/DD/YYYY)		13. Certificate #		14. Sex <input type="checkbox"/> M <input type="checkbox"/> F	15. Phone Number ( )			16. Zip Code	
	17. Relationship to Certificateholder/Employee: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						18. Employer Name _____ Address _____			

<b>CERTIFICATEHOLDER / EMPLOYEE</b>	19. Cert.Hldr./Emp. ID#/SSN#		20. Employer Name		21. Group #		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. Certificate #		
	22. Certificateholder/Employee Name (Last, First, Middle)						33. Other Certificateholder'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. Certificateholder/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 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.						40. Employer/School Name _____ Address _____ PO _____					
	X Signed (Patient/Guardian) _____ Date (MM/DD/YYYY) _____						41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity. X Signed (Employee/certificateholder) _____ Date (MM/DD/YYYY) _____					

<b>BILLING DENTIST</b>	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? <input type="checkbox"/> Yes <input type="checkbox"/> No If service already commenced: Date appliances placed _____ Total mos. of treatment remaining _____			
	55. If prosthesis (crown, bridge, dentures), is this initial placement? <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

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee	Admin. Use Only

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

## **GROUP DENTAL PLAN**

Dear Certificateholder/Claimant:

Enclosed is a claim form for filing for dental benefits. Please have the claim form completed as follows:

### **FILING FOR DENTAL BENEFITS:**

1. Please complete the Patient section, boxes 8-18.
2. Please complete the Certificateholder/Employee section. **Excluding boxes 31-38 and 40.**
3. Please have your dentist complete the Billing Dentist section, Boxes 42- 66.  
**Excluding box 53.**

**Processing time for a routine claim is 10 business days. Failure to have this form properly completed may delay processing of your claim. Please mail completed form to the address noted in boxes 3 through 7. You may fax your completed claim to 1-866-849-2970.**

**Should you have any questions, please do not hesitate to contact the Customer Service Center at 1-866-849-0017.**