Dental Claim Form

Check one:

☐ **Dentist's pre-treatment estimate**

☐ **Dentist's statement of actual services**

Carrier name and address

PATIENT COVERAGE INFORMATION

1. Patient name — first / m.i. / last

2. Relationship to employee — ☐ self ☐ child ☐ spouse ☐ other_____

3. Sex — m f

4. Patient birth date — MM DD YYYY

5. If full time student — school / city

6. Employee/subscriber name and mailing address

7. Employee/subscriber soc. sec. or I.D. number

8. Employee/subscriber birth date — MM DD YYYY

9. Employer (company) name and address

10. Group number

11. Is patient covered by another dental plan? ☐ yes ☐ no — If yes, complete 12-a.
Is patient covered by a medical plan? ☐ yes ☐ no

12-a. Name and address of carrier(s)

12-b. Group no.(s)

13. Name and address of other employer(s)

14-a. Employee/subscriber name (if different than patient's)

14-b. Employee/subscriber soc. sec. or I.D. number

14-c. Employee/subscriber birth date — MM DD YYYY

15. Relationship to patient — ☐ self ☐ parent ☐ spouse ☐ other_____

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

▶ Signed (Patient, or parent if minor) Date

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

▶ Signed (Insured person) Date

BILLING DENTIST

16. Name of Billing Dentist or Dental Entity
LOUISVILLE DENTAL ASSOCIATES

17. Address where payment should be remitted
1760 Centennial Drive

City, State, Zip
Louisville, CO 80027

18. Dentist Soc. Sec. or T.I.N.
84-1207272

19. Dentist license no.
104857

20. Dentist phone no.
(303) 665-7505

21. First visit date current series

22. Place of treatment — Office Hosp. ECF Other

23. Radiographs or models enclosed? No Yes How many?

24. Is treatment result of occupational illness or injury? No Yes — If yes, enter brief description and dates.

25. Is treatment result of auto accident? No Yes

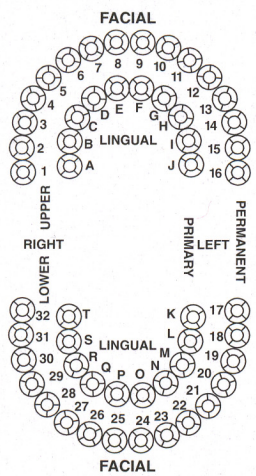
26. Other accident? No Yes

27. If prosthesis, is this initial placement? No Yes — (If no, reason for replacement)

28. Date of prior placement

29. Is treatment for orthodontics? No Yes — If services already commenced enter: / Date appliances placed / Mos. treatment remaining

Identify missing teeth with "x"



30. Examination and treatment plan — List in order from tooth no. 1 through tooth no. 32—Use charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year	Procedure number	Fee

For administrative use only

31. Remarks for unusual services

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

▶ Signed (Treating Dentist) License Number Date

Total Fee Charged	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

Item 4045