ATTENDING DENTIST'S STATEMENT

IMPORTANT: ***Please use separate copies of this form for ACTUAL SERVICES and PRE-DETERMINATION purposes.***

☐ **ACTUAL SERVICES**
☐ **PRE-DETERMINATION**

Claims Department
P.O. Box 38300
Phoenix, AZ 85069-8300

PATIENT SECTION

1. Patient name — first / m.i. / last

2. Relationship to employee — ☐ self ☐ child ☐ spouse ☐ other ______

3. Sex — m | f

4. Patient birthdate — MM | DD | YYYY

5. If full time student — school / city

6. Employee/subscriber name and mailing address

7. Employee/subscriber soc. sec. number

8. Employee/subscriber birthdate — MM | DD | YYYY

9. Employer (Company)

10. Group number

11. Is patient covered by another plan of benefits?
Dental ______
Medical ______

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

12-b. Group no.(s)

13. Name and address of employer

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

14-b. Employee/subscriber soc. sec. number

14-c. Employee/subscriber birthdate — 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 directly to the below named dentist of the group insurance benefits otherwise payable to me.

► ______ Signed (Insured person) ______ Date

DENTIST SECTION

16. Dentist name

17. Mailing address

City, State, Zip

18. Dentist Soc. Sec. or T.I.N.

19. Dentist license no.

20. Dentist phone no.

21. First visit date current series

22. Place of treatment — Office | Hosp. | ECF | Other

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

	No	Yes	If yes, enter brief description and dates.
24. Is treatment result of occupational illness or injury?			
25. Is treatment result of auto accident?			
26. Other accident?			
27. Are any services covered by another plan?			
28. If prosthesis, is this initial placement?			(If no, reason for replacement) — 29. Date of prior placement

Identify missing teeth with "X"

32. Remarks for unusual services

31. 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.) Line No.	Date service performed Mo. Day Year	Procedure number	Fee	For administrative use only
		1				
		2				
		3				
		4				
		5				
		6				
		7				
		8				
		9				
		10				
		11				
		12				
		13				
		14				
		15				

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.

► ______ Date ______
Signed (Dentist)

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