

## ATTENDING DENTIST'S STATEMENT

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CH	ECK ONE: USE ONE FORM	PER CLAIM					MAIL TO: (CLAIM)	ADDRESS ON T	HE B	ACK O	F THE N	MEMBER'S ID (	CARD)		
	PRE-TREATMENT ESTIMA	ΓΕ	☐ STATEN	MENT OF A	CTUAL SERVIC	ES							19 November 200 No		
	PATIENT NAME FIRST							IONSHIP TO EMPLOYEE F CHILD OTHER STORY MO. / DAY / YEAR  7. EMPLOYEE/SUBSCRIBER IDENTIFICATION NUMBER MO. / DAY / YEAR  8. EMP/SUB BIRTH DATE MO. / DAY / YEAR							
ATION	6. EMPLOYEE/SUBSCRIBER NAME AND MAILING ADDRESS														
PATIENT INFORMATION	9. EMPLOYER (COMPANY) NAME AND ADDRESS						10. GROUP NO.	11. IS PATIENT COVERED BY ANOTHER PLAN? IF YES, COMPLETE BOXES 12A THRU 15.  DENTAL: □ YES □ NO MEDICAL: □ YES □ NO							
ENT	12-A. NAME AND ADDRESS OF CARRIER(S)							12-B. GROUP	NUMB	ER(S)					
PATI	13. NAME AND ADDRESS OF EMPLOYER							14-A. OTHER EMPLOYEE/SUBSCRIBER NAME (IF DIFFERENT THAN PATIENT'S)							
	14-B. EMPLOYEE/SUBSCRIBER IDENTIFICATION NUMBER 1			14-C.	EMPLOYEE/SUB MO. / DAY / YEA			IO. REDITIONS IN CONTRACTOR OF THE CONTRACTOR OF							
BE IN ACCO	ERSTAND THAT BLUE CROSS AND RMATION, WHETHER FURNISHED I ACCORDANCE WITH THE FEDERA UNTABILITY ACT OF 1996). I AUTH I AM RESPONSIBLE FOR ALL COS	BY ME OR OBTAIN IL PRIVACY REGUI FORIZE RELEASE	VED FROM OTHER SOL LATIONS UNDER HIPA OF ANY INFORMATION	JRCES SUCH A (HEALTH IN	AS MEDICAL PROV ISURANCE PORTABI	iders, shall Lity and	I HEREBY AUTHORIZE PAY BELOW NAMED DENTAL E		ENTAL	BENEF	TITS OTH	erwise Payabl	E TO ME DIR	ECTLY TO THE	
SIGN	ED (PATIENT, OR PARENT IF M		SIGNED (INSURED PERSON) DATE												
	16. DENTIST NAME						ITIONAL ILLNESS OR INJURY?								
NOI	17. MAILING ADDRESS						ACCIDENT?	MENT RESULT OF AUTO IT?							
DENTIST INFORMATION	CITY STATE				ZIP		26. OTHER ACCIDENT?							Application of the Control of the Co	
	18. DENTIST SOC. SEC. NO. OR TIN 19. DENTIST LI		ENSE NO.			27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?				ar No.	DEACON FOR RI	CDI ACEMENI	D		
DENT	21. FIRST VISIT DATE CURRENT SERIES  22. PLACE OF TREATMENT OFFICE/HOSP/ECF/OTHER			23. RADIOGRAPHS OR MODELS ENCLOSED? ☐ YES ☐ N		28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?					REASON FOR RI F PRIOR PLACE		1)		
					HOW MANY?		29. IS TREATMENT FOR ORTHODONTIC					NCE PLACED:	RE	OS. TREATMENT MAINING:	
	IDENTIFY MISSING TEETH WITH "X"						EATMENT PLAN - LIST IN ORD	DER FROM TOOTH	T			PROCEDURE	CHARTING :	SYSTEM FOR ADMINISTRATIVE	
	FAC (5) (8) (6) (8) (7) (8) (6) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1	9 10 11 F G	12) (13) (14)	TOOTH # OR LETTER			DESCRIPTION OF SERVICE AYS, PROPHYLAXIS, MATERIA	ILS USED, ETC.)		erfori		NUMBER		USE ONLY	
	(2) (B)	(11)	(15)						1						
1		O	16	***************************************											
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	PRIMARY TON		PERMANENT												
	PRIMARY TON	VER T	V 6												
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	PRIMARY TON	VER THE K	PERMANENT												
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