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ATTENDING DENTIST'S STATEMENT

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

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

MAIL TO: 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 ☐ Male ☐ Female	4. Patient birth date MM / DD / YYYY / /	5. If full time student School City
6. Employee/subscriber name and mailing address	7. Employee/subscriber social security number	8. Employee/subscriber birth date 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 number(s)	13. Name and address of employer	
14-a. Employee/subscriber name (if different than patient's)	14-b. Employee/subscriber Social Security Number	14-c. Employee/subscriber birth date MM / DD / YYYY / /	15. Relationship to patient ☐ Self ☐ Child ☐ Spouse ☐ Other	

I have reviewed the following treatment plan, and 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.

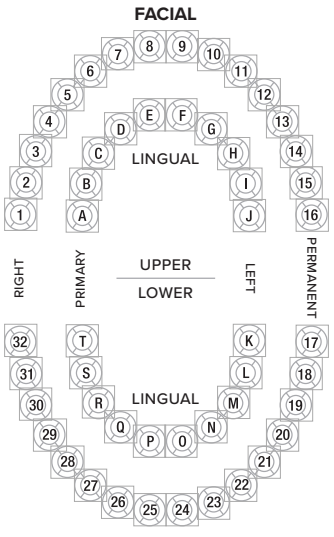
▶ _____ _____
Signed (Insured person) Date

PATIENT SECTION

16. Dentist name	17. Mailing address	City, State, Zip			
18. Dentist Social Security Number or T.I.N.	19. Dentist license number	20. Dentist phone number	21. First visit date current series	22. Place of treatment ☐ Office ☐ Hosp. ☐ ECF ☐ Other	23. Radiographs or models enclosed? ☐ Yes ☐ No How many?

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

IDENTIFY MISSING TEETH WITH "×"



29. Examination and treatment plan — List in order from tooth number 1 through tooth number 32 *(use charting system)*

TOOTH # OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICES PERFORMED	PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY
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30. 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 (Dentist) Date

Total fee charged		
Max. allowable		
Deductible		
Carrier %		
Carrier pays		
Patient pays		

