Dental Claim Form

Check one:
☐ Dentist's pre-treatment estimate
☐ Dentist's statement of actual services

Carrier name and address

PATIENT COVERAGE INFORMATION

Patient name: first | m.i. | last
Relationship to employee: ☐ self ☐ child ☐ spouse ☐ other
Sex: m f
Patient birthdate: MM DD YYYY
If full time student: school | city

Employee/subscriber name and mailing address
Employee/subscriber soc. sec. or I.D. number
Employee/Subscriber birthdate: MM DD YYYY
Employer (company) name and address
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 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 of the dental benefits otherwise payable to me directly to the below-named dental entity.
Signed (Insured person) Date

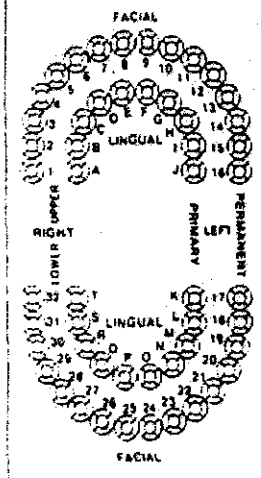
BILLING DENTIST

A. Stephen Pauly, D.D.S.
1513 Riverside Avenue
Fort Collins, CO 80524

	No	Yes	
24. Is treatment result of occupational illness or injury?			If yes, enter brief description and dates
25. Is treatment result of auto accident?			
26. Other accident?			

18. Dentist Soc. Sec. or T.I.N.: 84-1106564
19. Dentist license no.: 105062
20. Dentist phone no.: (970)484-4255
27. If prosthesis, is this initial placement? (If no, reason for replacement) 28. Date of prior placement
21. First visit date current series
22. Place of treatment: Office Hosp ECF Other
23. Radiographs or models enclosed? No Yes How many?
29. Is treatment for orthodontics? 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	

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Form Approved by the
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