# Dental Claim Form

See reverse for instructions

1. ☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services Provider ID #

2. ☐ Medicaid Claim ☐ EPSDT Prior Authorization # Patient ID #

3. Carrier name and address

**PATIENT COVERAGE INFORMATION**

4. Patient name first m.i. last

5. Relationship to employee ☐ self ☐ child ☐ spouse ☐ other

6. Sex m f

7. Patient birthdate MM DD YYYY

8. If full time student school city

9. Employee/subscriber name and mailing address

10. Employee/subscriber dental plan I.D. number

11. Employee/subscriber birthdate MM DD YYYY

12. Employer (company) name and address

13. Group number

14. Is patient covered by another dental plan yes no If yes, complete 15-a. Is patient covered by a medical plan? yes no

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

15-b. Group no.(s)

16. Name and address of other employer(s)

17-a. Employee/subscriber name (if different from patient's)

17-b. Employee/subscriber dental plan I.D. number

17-c. Employee/subscriber birthdate MM DD YYYY

18. Relationship to patient ☐ self ☐ parent ☐ spouse ☐ other

19. **I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.**

Signed (Patient* – see reverse) Date

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

Signed (Employee/subscriber) Date

**BILLING DENTIST**

21. Name of Billing Dentist or Dental Entity

BEVERLY A. WOSS, D.D.S.

22. Address where payment should be remitted

9401 Wilshire Blvd., Suite 1140

23. City, State, Zip

Beverly Hills, CA 90212

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

25. Dentist license no.

26. Dentist phone no.

(310) 275-5504

27. First visit date current series

28. Place of treatment Office Hosp. ECF Other

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

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

31. Is treatment result of auto accident?

32. Other accident?

33. If prosthesis, is this initial placement? (If no, reason for replacement)

34. Date of prior placement

35. Is treatment for orthodontics? If service already commenced enter: Date appliances placed Mos. treatment remaining

36. Identify missing teeth with "x"

FACIAL

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

A B C D E F G H I J

LINGUAL

UPPER LOWER RIGHT PRIMARY LEFT PERMANENT

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

T S R Q P O N M L K

LINGUAL

FACIAL

37. Examination and treatment plan – List in order from tooth no. 1 through tooth no. 32 – Using 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

38. Remarks for unusual services

39. **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

40. Address where treatment was performed

City State Zip

41. Total Fee Charged

42. Payment by other plan

Max. Allowable

Deductible

Carrier %

Carrier pays

Patient pays

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#19406 – #29406 – Medical Arts Press 1-800-328-2179