1200 Ridgefield Blvd., Ste. 215
Asheville, NC 28806
Telephone: 828-670-9145
Fax: 828-670-9155

DENTAL CLAIM FORM

TO BE COMPLETED BY EMPLOYEE – USE BLACK INK ONLY

1. Employer's Name
2. Policy/Group #
3. Employee's ID
4. Employee's Name
5. Employee's Birthdate (MM/DD/YYYY)
6. ☐ Active ☐ Retired
   Date Retired
7. Employee's Full Address ☐ New Address
8. Employee's Daytime Phone
   ( )
9. Patient's Name
10. Patient's ID #
11. Patient's Birthdate
12. Patient's Relationship to Employee
    ☐ Self ☐ Spouse ☐ Child ☐ Other
13. Patient's Address
    (if different from Employee)
14. Patient's Sex
    ☐ Male ☐ Female
15. Full-time Student
    ☐ Yes ☐ No
16. Graduating Date
17. School/City
18. Patient's Marital Status
    ☐ Married ☐ Single
19. Is Patient Employed?
    ☐ No ☐ Yes
20. Employer Name & Address
21. Is claim related to an accident?
    ☐ No ☐ Yes Date of accident Time ☐ AM ☐ PM
22. Is claim related to employment?
    ☐ No ☐ Yes
23. Are any family members' expenses covered by another group health plan, group pre-payment plan (BCBS, etc.), no-fault auto insurance, Medicare or any federal, state, or local government plan? ☐ No ☐ Yes
24. If yes, provide policy/contract holder name, policy number, and name/address of Company/administrator
25. Member's ID #
26. Member's Name
27. Member's Birthdate
28. I authorize payment of dental benefits to the dentist or supplier of service.
    ➡ *Patient/Authorized Person Signature* *Date*

TO BE COMPLETED BY DENTIST – USE BLACK INK ONLY

30. This a request for ☐ Pre-Treatment Estimate ☐ Predetermination/Preauthorization # ☐ Services Rendered
31. Dentist's Name & Full Address
32. NPN #
33. License #
34. Phone ( )
35. Taxpayer ID for 1099 Reporting (required by law)
36. First Visit Date Current Series
37. Place of Treatment ☐ Office ☐ Hospital ☐ ECF ☐ Other
38. Radiographs or models enclosed? ☐ No ☐ Yes How Many?

Is treatment the result of	No	Yes	If yes, enter brief description and dates	
39. Occupational illness or injury				
40. Auto accident				
41. Other accident				
42. Are any services covered by another plan?				
43. If prosthesis, is this initial placement?			If no, date of prior placement/reason for replacement	
44. Is treatment for orthodontics?			Date appliance placed	Initial Appliance Fee
			No. months of treatment	Monthly Fee
			No. months remaining	Total Case Fee

45. To expedite claim handling, identify all missing teeth with 'X'.

IDENTIFY MISSING TEETH WITH "X"
FACIAL
LINGUAL
UPPER
LOWER
RIGHT
LEFT
PRIMARY
PERMANENT

46. Examination/treatment plan. List in order, tooth # 1 - 32.

Tooth #/ Letter	Date previously extracted	Surface	Description of Service (xray, prophylaxis, materials used, etc.)	Date Service Performed MM	DD	YYYY	Procedure #	Fee

47. 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 this patient and intend to accept for those procedures.
    ➡ *Dentist's Signature* *Date*
48. NPN #

Total charge $ ____________
Amount paid $ ____________
Balance due $ ____________