

Dental Claim Form



333 E. Six Forks Road
Raleigh, NC 27609

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

NON-PROFIT ORGANIZATION

1. Patient Name first m.i. last		2. Relationship to employee <input type="checkbox"/> -self <input type="checkbox"/> -child <input type="checkbox"/> -spouse <input type="checkbox"/> -other		3. Sex M F	4. Patient birthdate MM DD YYYY		5. If full time student School City		
6. Employee/subscriber name and mailing address			7. Employee/subscriber soc. sec. or I.D. number		8. Employee/subscriber birthdate MM DD YYYY		9. Employer (company) name/address		10. 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 <input type="checkbox"/> -self <input type="checkbox"/> -parent <input type="checkbox"/> -spouse <input type="checkbox"/> -other			

I ACCEPT THE FOREGOING TREATMENT PLAN AND AUTHORIZE RELEASE OF INFORMATION RELATING HERETO, I CERTIFY THE TRUTH OF ALL PERSONAL INFORMATION CONTAINED ABOVE.

WE HAVE REVIEWED AND APPROVED THIS ATTENDING DENTIST'S STATEMENT, THE COMPUTATIONS AND ANY ADJUSTMENTS MADE BY D.D.P. OF N.C.

Signed (Patient, or parent if minor) _____ Date _____

Signed (Insured person) _____ Date _____

16. Name of Billing Dentist or Dental Entity		24. Is treatment result of occupational illness or injury?		No	Yes	If yes, enter brief description and dates		
17. Address where payment should be remitted. City, State, Zip		25. Is treatment result of auto accident?						
18. Dentist's Soc. Sec. or T.I.N. 19. Dentist license no. 20. Dentist phone no.		26. Other accident?						
21. First visit date current series		22. Place of treatment Office Hosp. ECF Other		23. Radiographs or models enclosed?		No	Yes	How Many?
				27. If prosthesis, is this initial placement?			(If no, reason for placement)	28. Date of prior placement
				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 shown						For administrative use only
	Tooth # or letter	Surface	Description of service (including X-rays, prophylaxis, materials used, ect.)	Date service performed Mo. Day Year	Procedure number	Fee	

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. I REQUEST PAYMENT IN ACCORDANCE WITH D.D.P. OF N.C. PARTICIPATING DENTIST RULE.

Signed (Treating Dentist) _____ Date _____

Total Fee Charged
Max. Allowable
Deductible
Carrier%
Carrier pays
Patient pays