

ATTENDING DENTIST'S STATEMENT

- DENTIST'S PREDETERMINATION REQUEST
 DENTIST'S STATEMENT OF ACTUAL SERVICES



240 Venture Circle
 Nashville, Tennessee 37228
 (615) 255-3175
 CLAIM: (800) 223-3104

1. PATIENT		2. RELATIONSHIP TO SUBSCRIBER SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>				3. SEX <input type="checkbox"/> M <input type="checkbox"/> F	4. PATIENT BIRTH DATE	5. FULL TIME STUDENT <input type="checkbox"/> Yes <input type="checkbox"/> No
6. SUBSCRIBER NAME (First, Middle, Last)			7. SUBSCRIBER SOC. SEC. NO.		8. SUBSCRIBER BIRTH DATE			School City _____
SUBSCRIBER MAILING ADDRESS			10. EMPLOYER (COMPANY) NAME					PATIENT IS DEPENDENT UPON SUBSCRIBER FOR SUPPORT & MAINTENANCE AND HAS NEVER BEEN MARRIED <input type="checkbox"/> YES <input type="checkbox"/> NO
CITY, STATE, ZIP			(COMPANY ADDRESS)					

11. GROUP NO.	IF PATIENT IS COVERED BY ANOTHER PLAN COMPLETE 13-15	13. SUBSCRIBER NAME	SOC. SEC. NO.	BIRTH DATE
14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13		GROUP NO.	15. NAME AND ADDRESS OF CARRIER	
I HAVE REVIEWED THE TREATMENT PLAN SHOWN BELOW. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.		CHECK THIS BOX IF YOU WOULD LIKE FOR PAYMENT TO BE SENT TO YOUR DENTIST WHO IS A NON PARTICIPATING DENTIST <input type="checkbox"/>		
SIGNED (PATIENT, OR PARENT IF MINOR)		DATE		
16. DENTIST NAME		24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS, INJURY?		
17. MAILING ADDRESS		25. IS TREATMENT RESULT OF AUTO ACCIDENT?		
CITY, STATE, ZIP		26. OTHER ACCIDENT?		
18. DENTIST SOC. SEC. NO. OR TIN	19. DENTIST LICENSE NO.	20. DENTIST PHONE NO.	27. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?	

21. FIRST VISIT DATE CURRENT SERIES		22. PLACE OF TREATMENT OFFICE <input type="checkbox"/> HOSP. <input type="checkbox"/> RCP <input type="checkbox"/> OTHER <input type="checkbox"/>		23. RADIOGRAPHS OR MODELS ENCLOSED	NO <input type="checkbox"/> YES <input type="checkbox"/>	HOW MANY	28. IS TREATMENT ORTHODONTICS	NO <input type="checkbox"/> YES <input type="checkbox"/>	IF SERVICES ALREADY COMMENCED ENTER:	DATE APPLIANCES PLACED	MOS. TREATMENT REMAINING
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IDENTIFY MISSING TEETH WITH AN "X" 30. REMARKS FOR UNUSUAL SERVICES	29. EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 - USE CHARTING SYSTEM SHOWN										
	TOOTH NO. OR LETTER	SURFACE	DESCRIPTION OF SERVICE INCLUDING X-RAYS, PROPHYLASIX, MATERIALS USED, ETC.) LINE NO.	DATE SERVICE PERFORMED	PROCEDURE NO.	FEE					

I HAVE REVIEWED THE ABOVE TREATMENT PLAN. THE COURSE OF TREATMENT LISTED ABOVE IS NECESSARY IN MY PROFESSIONAL JUDGEMENT AND I REQUEST PRE-DETERMINATION			TOTAL FEE CHARGED	
SIGNED (DENTIST)			DATE	
I HEREBY CERTIFY THAT I HAVE PERFORMED THE PROCEDURES AS INDICATED BY DATE, AND THE PROCEDURES WERE NECESSARY IN MY PROFESSIONAL JUDGEMENT			DEDUCTIBLE APPLIED	
SIGNED (DENTIST)			DATE	
			PATIENT'S TOTAL PAYMENT	
			DELTA'S PAYMENT	
			MAXIMUM USED	