DENTAL CLAIM FORM

EDI PAYER ID # 94177
P.O. Box 2500
San Francisco, CA 94126
415/986-6276 or 888/877-8363

HEADER INFORMATION

Type of Transaction (Check all applicable boxes)
☐ State of Actual Services ☐ Request for Predetermination/Preauthorization ☐ EPSDT/Title XIX

Predetermination/Preauthorization No.

PRIMARY SUBSCRIBER INFORMATION			**PATIENT INFORMATION**		
Name (Last, First, M.I., Suffix), Address, City, State Zip Code			Name (Last, First, M.I., Suffix), Address, City, State Zip Code		
Date of Birth	Gender ☐ M ☐ F	Subscriber Identifier (SSN or ID#)	Relationship to Primary Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other		Student Status ☐ FTS ☐ PTS
Plan/Group No.	Employer Name		Date of Birth	Gender ☐ M ☐ F	Patient ID (by Dentist)

PRIMARY PAYER INFORMATION	**OTHER COVERAGE** Complete this section if you have other dental/medical coverage.		
Name, Address, City State, Zip Code	Subscriber Name (Last, First, Middle Initial, Suffix)		
	Date of Birth	Gender ☐ M ☐ F	Subscriber Identifier (SSN or ID#)
	Plan/Group Number	Relationship to Primary Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other	
	Other Carrier Name, Address, City, State Zip Code		

RECORD OF SERVICE PROVIDED

	Procedure Date	Area of Oral Cavity	Tooth System	Tooth Member(s) or Lesser(s)	Tooth Surface	Procedure Code	Description	Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION	**Permanent**		**Primary**		Other Fee(s)	
Place an "X" on each missing tooth.	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	Total Fee	
	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		

Remarks

AUTHORIZATIONS

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or 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 by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____
Patient/Guardian Signature Date

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X_____
Patient/Guardian Signature Date

ANCILLARY CLAIM/TREATING INFORMATION

Place of Treatment
☐ Provider Office ☐ Hospital ☐ ECF ☐ other

Number of Enclosures (00 to 99)
Radiograph(s) [ ] Oral Image(s) [ ] Model(s) [ ]

Is Treatment for Orthodontics?
☐ No ☐ Yes-- Date appliance placed _____
Months of treatment remaining _____

Replacement of Prosthesis?
☐ No ☐ Yes—Date of prior placement _____

Treatment Resulting from:
☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

Date of Accident | Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claims on behalf of the patient or insured/subscriber.)

Name, Address, City, State Zip Code

NPI	License Number	SSN or TIN
Phone Number	Additional Provider ID	

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) orhave been completed and that the fees submitted are the actual fees I have charged and intend to collect for those purposes.

Signed (Treating Dentist) Date

NPI	License Number	Provider Specialty Code
Address		
Phone Number	Provider ID	