

Dental Claim Form

1. <input type="checkbox"/> Dentist's pre-treatment estimate Specialty (see backside) <input type="checkbox"/> Dentist's statement of actual services 2. <input type="checkbox"/> Medicaid Claim Prior Authorization # <input type="checkbox"/> Electronic Claim #	3. Submit Claims to: National Benefits, Inc. P.O. Box 263; Parsippany, NJ 07054 Claim Inquiries Call: 800-258-0103
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PATIENT	4. Patient Name (Last, First, Middle) <input type="checkbox"/> Check here if disabled	5. Address	6. City	7. State	
	8. Date of Birth (MM/DD/YYYY) / /	9. Patient ID#/SS#	10. Sex <input type="checkbox"/> M <input type="checkbox"/> F	11. Phone Number ()	12. Zip Code
	13. Relationship to Subscriber/Employee: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			14. If full time student, print school and attach student enrollment documentation (see instructions on reverse). <input type="checkbox"/> Full-time Student <input type="checkbox"/> Part-time Student	

SUBSCRIBER/EMPLOYEE	15. Subs./Emp. ID#/SS#	16. Employer Name and Address	17. Group #	OTHER POLICIES	27. Is Patient covered by another plan for services listed on this form? <input type="checkbox"/> No (Skip 28-33) <input type="checkbox"/> Yes: <input type="checkbox"/> Dental or <input type="checkbox"/> Medical	28. Policy #		
	18. Subscriber/Employee Name (Last, First, Middle)				29. Other Subscriber's Name (If Different)			
	19. Address				20. Phone Number ()	30. Date of Birth (MM/DD/YYYY) / /	31. Sex <input type="checkbox"/> M <input type="checkbox"/> F	32. Program Name
	21. City	22. State	23. Zip Code		33. Employer Name _____ Address _____			
	24. Date of Birth (MM/DD/YYYY) / /	25. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other			26. Sex <input type="checkbox"/> M <input type="checkbox"/> F	34. Subscriber/Employee Status <input type="checkbox"/> Employed <input type="checkbox"/> Part-time Status		
	36. 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 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 to the carrier of any information and documentation relating to this claim and/or any request for pre-treatment estimate without any further authorization in the future. X _____ Signed (Patient/Guardian) Date (MM/DD/YYYY)				35. Employer Name _____ Address _____			
37. LEFT BLANK INTENTIONALLY								

BILLING DENTIST	38. Name of Billing Dentist or Dental Entity	39. E-mail	40. Phone Number ()	41. Fax ()	42. Provider ID #	43. Dentist Soc. Sec. or T.I.N.	
	44. Address			45. Dentist License # / State	46. First visit date of current series:	47. Place of treatment <input type="checkbox"/> Office <input type="checkbox"/> Hosp. <input type="checkbox"/> ECF <input type="checkbox"/> Other	
	48. City	49. State	50. Zip Code		51. Radiographs or models enclosed? <input type="checkbox"/> Yes, How many? _____ <input type="checkbox"/> No		52. Is treatment for orthodontics? <input type="checkbox"/> Yes <input type="checkbox"/> No If service already commenced: Date appliances placed _____ Total mos. of treatment remaining _____
	53. If prosthesis (crown, bridge, dentures), is this initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, reason for replacement: _____ Date of prior placement: _____				54. Is treatment result of occupational illness or injury? <input type="checkbox"/> No <input type="checkbox"/> Yes Brief description and dates _____		
					55. Is treatment result of: <input type="checkbox"/> auto accident? <input type="checkbox"/> other accident? <input type="checkbox"/> neither Brief description and dates _____		

56. Diagnosis Code Index **LEFT BLANK INTENTIONALLY**

57. Examination and treatment plans - List teeth in order										Admin. Use Only																
Date service completed	Mo.	Day	Year	Tooth	Surface	Procedure Code	Qty	Description	Fee																	
1.						1.			1.																	
2.						2.			2.																	
3.						3.			3.																	
4.						4.			4.																	
5.						5.			5.																	
6.						6.			6.																	
7.						7.			7.																	
8.						8.			8.																	
58. Identify all missing teeth with "X" using the Universal/National System																										
Permanent					Primary					Total Fee																
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	Payment by other plan
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	Max. Allowable
59. Remarks for unusual services										Deductible																
										Carrier %																
										Carrier pays																
										Patient pays																

60. 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. For pre-treatment estimates, the fees submitted are the actual fees I intend to collect for those procedures.	61. Address where treatment was performed		
>	62. City	63. State	64. Zip Code
Print Name of Treating Dentist	Signature of Treating Dentist	License Number	Date