Dental Network of America®

ATTENDING DENTIST'S STATEMENT

CHECK ONE: USE ONE FORM PER SERVICE LINE

☐ PRE-TREATMENT ESTIMATE ☐ STATEMENT OF ACTUAL SERVICES

MAIL TO: DENTAL NETWORK OF AMERICA
P.O. BOX 23060
BELLEVILLE, ILLINOIS 62223-0060

PATIENT INFORMATION

1. PATIENT NAME — FIRST / M.I. / LAST
2. RELATIONSHIP TO EMPLOYEE — ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER
3. SEX — ☐ M ☐ F
4. PATIENT BIRTH DATE — MO. / DAY / YEAR
5. IF FULL-TIME STUDENT — SCHOOL / CITY
6. EMPLOYEE/SUBSCRIBER NAME AND MAILING ADDRESS
7. EMPLOYEE/SUBSCRIBER IDENTIFICATION NUMBER
8. EMP/SUB BIRTH DATE — MO. / DAY / YEAR
9. EMPLOYER (COMPANY) NAME AND ADDRESS
10. GROUP NO.
11. IS PATIENT COVERED BY ANOTHER PLAN? IF YES, COMPLETE BOXES 12A THRU 15. DENTAL: ☐ YES ☐ NO MEDICAL: ☐ YES ☐ NO
12-A. NAME AND ADDRESS OF CARRIER(S)
12-B. GROUP NUMBER(S)
13. NAME AND ADDRESS OF EMPLOYER
14-A. OTHER EMPLOYEE/SUBSCRIBER NAME (IF DIFFERENT THAN PATIENT'S)
14-B. EMPLOYEE/SUBSCRIBER IDENTIFICATION NUMBER
14-C. EMPLOYEE/SUBSCRIBER BIRTH DATE — MO. / DAY / YEAR
15. RELATIONSHIP TO PATIENT ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER

I UNDERSTAND THAT BLUE CROSS AND BLUE SHIELD'S USE OR DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION, WHETHER FURNISHED BY ME OR OBTAINED FROM OTHER SOURCES SUCH AS HEALTH PROVIDER, SHALL BE IN ACCORDANCE WITH THE FEDERAL PRIVACY REGULATIONS UNDER HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996). I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM, I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

SIGNED (PATIENT, OR PARENT IF MINOR) DATE

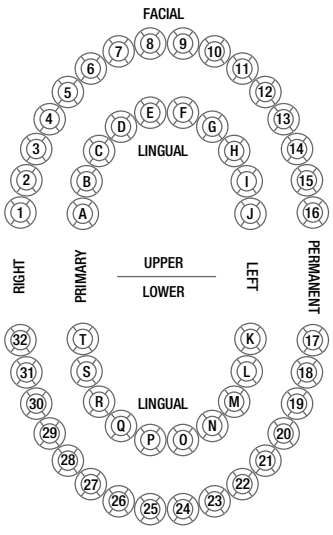
I HEREBY AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THE BELOW NAMED DENTAL ENTITY.

SIGNED (INSURED PERSON) DATE

DENTIST INFORMATION

16. NAME OF BILLING DENTIST OR DENTAL ENTITY
17. ADDRESS WHERE PAYMENT SHOULD BE REMITTED
CITY / STATE / ZIP
18. DENTIST SOC. SEC. NO. OR TIN
19. DENTIST LICENSE NO.
20. DENTIST PHONE
21. FIRST VISIT DATE CURRENT SERIES
22. PLACE OF TREATMENT OFFICE/HOSP./ECF/OTHER
23. RADIOGRAPHS OR MODELS ENCLOSED? ☐ YES ☐ NO HOW MANY?
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? NO ☐ YES ☐ IF YES, ENTER BRIEF DESCRIPTION AND DATES
25. IS TREATMENT RESULT OF AUTO ACCIDENT? NO ☐ YES ☐
26. OTHER ACCIDENT? NO ☐ YES ☐
27. ARE ANY SERVICES COVERED BY ANOTHER PLAN? NO ☐ YES ☐
28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? NO ☐ YES ☐ (IF NO, REASON FOR REPLACEMENT) DATE OF PRIOR PLACEMENT
29. IS TREATMENT FOR ORTHODONTICS? ☐ YES ☐ NO — IF SERVICES ALREADY COMMENCED, ENTER: — DATE APPLIANCE 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 SYSTEM

TOOTH # OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICES PERFORMED	PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY

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.

SIGNED (TREATING DENTIST)

LICENSE NUMBER DATE

ADDRESS WHERE TREATMENT WAS PERFORMED CITY STATE ZIP

REMARKS FOR UNUSUAL SERVICES

TOTAL FEE CHARGED		
PAYMENT BY OTHER PLAN		
MAX ALLOWABLE		
DEDUCTIBLE		
CARRIER %		
CARRIER PAYS		
PATIENT PAYS		

PLEASE REVIEW BEFORE SUBMITTING CLAIM

INFORMATION FOR PATIENT

1. Complete items one (1) through fifteen (15) in full to assure positive identification and prompt payment. Please print or type. Your group and Employer/Subscriber identification number can be found on your Dental Identification card.

2. You must sign the claim form under the Patient Information section indicating that the information is correct and authorizing payment.

3. The patient (or parent, if the patient is a minor) must sign the "Authorization to Release Information."

4. If total charges for the planned course of treatment can reasonably be expected to be $300 or more, it is recommended that a pre-treatment estimate be submitted prior to the commencement of the course of treatment. You and your dentist will be notified of benefits payable.

   Estimated benefits are subject to your coverage being in force at time services are performed and are subject to the specific limitations and exclusions listed in your benefit plan.

   Please refer to your Certificate of Coverage for a description of covered services, percentage of fees payable, limitations and exclusions.

   The completed form should be mailed to the address shown below.

   NOTE: Any person who knowingly presents false, incomplete or misleading information is guilty of a crime and is subject to a fine or imprisonment or both.

INFORMATION FOR ATTENDING DENTIST

1. Complete items 16 through 29 on the claim form.

2. If total charges for the planned course of treatment can reasonably be expected to be $300 or more, it is recommended that a pre-treatment estimate be submitted prior to the commencement of the course of treatment. You and your patient will be notified of benefits payable.

   You and your patient are free to pursue any treatment plan mutually agreed upon. Pre-estimation of benefits is only intended to avoid any misunderstanding among the patient, the dentist, and the insurance carrier, concerning the benefits allowed under terms of the coverage.

3. Generally, radiographs will not be required when submitting a claim. However, pre-operative radiographs may be requested in certain situations for dental consultant use in benefit determination.

4. We support the recommendation that original documentation should never leave your office. We encourage you to submit copied Radiographs or send your dental claim and radiographs electronically. Effective September 1, 2005, radiographs submitted will no longer be returned to your office unless accompanied by a self-addressed envelope.

5. If the subscriber has so authorized, benefit payment will be made directly to you.

   NOTE: Any person who knowingly presents false, incomplete or misleading information is guilty of a crime and is subject to a fine or imprisonment or both.

Mail Completed Form to: Dental Network of America
P.O. Box 23060
Belleville, Illinois 62223-0060