| American Dental Association Dental Claim Form  | ADA American Dental Association  |
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| HEADER INFORMATION   | TOTAL DESCRIPTION OF THE PROPERTY OF THE PROPE |
| 1. Type of Transaction (Mark all applicable boxes)   | At ranking on you give for onal health   |
| Statement of Actual Services Request for Predetermination/Preauthorization   |  |
| EPSDT/Title XIX  |  |
| 2. Predetermination/Preauthorization Number  | POLICYHOL DED/CHDCCDIDED INFORMATION (For Incurence Company, Named in #2)  |
| 2. Predetermination/Preauthonzation Number   | POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)  |
| Incinem Territorials for antiques transmit and at himself and research   | 12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code   |
| INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION  | subfigue by the ADA. Five relevant extracts from that seamed for   |
| 3. Company/Plan Name, Address, City, State, Zip Code   | The second secon |
|  | Search Server (Associated)   |
| te third-harty-payer recensure the claum traspromise econol could enal   | A. The force is designed so that the name and address fitting it days  |
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| age write as Yusaksor southwell is asset as a bone upon to   | dancet knorveng at opaga at the 1 Mai F and separately at the separately   |
| OTHER COVERAGE   | 16. Plan/Group Number 17. Employer Name  |
| 4. Other Dental or Medical Coverage? No (Skip 5-11) Yes (Complete 5-11)  | L. All deaths states form that he completed and as it is assed on the to   |
| 5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)   | PATIENT INFORMATION  |
| (2.114.11.0.0.1.0.1.0.1.0.1.0.1.0.1.0.1.0.   | 18. Relationship to Policyholder/Subscriber in #12 Above 19. Student Status  |
|  |  |
| 6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN or ID#)   | Self Spouse Dependent Child Other FTS PTS  |
| MF   | 20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code   |
| 9. Plan/Group Number 10. Patient's Relationship to Person Named in #5  | (B1), Yeaving a cilian with a section (B1).  |
| Self Spouse Dependent Other  |  |
| 11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code   | Clott deligion (1978) yearnoon bili al noladiste yelki al liber (1975).  |
| re amount the petrary carrier paid in the "Remarks" held cliem # 35).  | That is a country the mounting paid by the primary payer. You may indicent the   |
|  | 21. Date of Birth (MM/DD/CCYY)   |
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| ned by the federal government to all providers considered to be  | THE REPORT OF THE PROPERTY OF  |
| RECORD OF SERVICES PROVIDED  | THE STATE OF THE PARTY OF THE PROPERTY ASSESSED THE STATE OF THE STATE |
| 24. Procedure Date of Oral Tooth 27. Tooth Number(s) 28. Tooth 29. Proc  | sedure 30. Description 31. Fee   |
| (MM/DD/CCYY) Or Cavity System or Letter(s) Surface Cod   | de 30. Description 31. Fee   |
| 1 Juli otoelgan chanana shi d  | W ACIA and maril bondado ad esperior returns and 1997 ne-  |
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| at cerd is sect as Dennist anay be taked instelled on any other dennal of  | 1945 W. F. AUCTO GOARD SHE SATURED REPUBLISHED RANGE   |
| MISSING TEETH INFORMATION Permanent  | Primary 32. Other  |
| 34. (Place an "X" on each missing tooth)   | 2 13 14 15 16 A B C D E F G H I J Fee(s)   |
|  | 1 20 19 18 17 T S R Q P O N M L K 33.Total Fee   |
| 35. Remarks  | bellevill.   |
| Voccountry   2.0.0 versus large m  |  |
|  | ENGLOSO E 75 CORNERADO E DE POR EL REPUBBLICA.   |
| AUTHORIZATIONS Programme Authorizations  | ANCILLARY CLAIM/TREATMENT INFORMATION  |
| 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 prohibited by law, or   | 38. Place of Treatment  39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)   |
| the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health  | of Provider's Office Hospital ECF Other  |
| information to carry out payment activities in connection with this claim.   | 40. Is Treatment for Orthodontics?  41. Date Appliance Placed (MM/DD/CCYY)   |
| Various  | No (Skip 41-42) Yes (Complete 41-42)   |
| XPatient/Guardian signature Date   | 42. Months of Treatment 43. Replacement of Prosthesis? 44. Date of Prior Placement (MM/DD/CCYY)  |
| Tallett/ adardian signature  | Remaining  |
| 37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named  |  |
| dentist or dental entity.  | 45. Treatment Resulting from   |
| 122380221X   | Occupational illness/injury Auto accident Other accident   |
| Subscriber signature Date  | 46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State  |
| BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting  | TREATING DENTIST AND TREATMENT LOCATION INFORMATION  |
| claim on behalf of the patient or insured/subscriber)  | 53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple  |
| CONTROL OF THE PROPERTY OF THE | visits) or have been completed.  |
| 48. Name, Address, City, State, Zip Code   | io asti la estellizate 2 fra)  |
| XCT1838CCF 3   | X  |
| The Late of the Control of the Contr | Signed (Treating Dentist)  Date  |
| the full code set that is passed at:   | 54. NPI 55. License Number   |
|  | 56. Address, City, State, Zip Code S6A. Provider   |
| 49. NPI 50. License Number 51. SSN or TIN  | Specialty Code   |
| the rest of the second of the  | as extended as a record to left of tabused LETE or some former in the control blood of   |
| 52. Phone 52A. Additional  | 57. Phone , 58. Additional   |
| 52. Phone Sumber ( ) – 52A. Additional Provider ID   | 57. Phone Sumber ( ) – 58. Additional Provider ID  |