

Attending Dentist Statement

Dental Administrative Offices
555 Middle Creek Parkway, MS 420
Colorado Springs, Colorado 80921-5634
1-800-251-2585

- Check one:
 Dentist pre-treatment estimate
 Dentist statement of actual services

| | | | | | | | | | | |
|--|--|---|--|--|---|---|--|--|--|------------------|
| 1. PATIENT NAME (First, Middle, Last) | | 2. RELATIONSHIP TO POLICYHOLDER <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other | | 3. SEX <input type="checkbox"/> M <input type="checkbox"/> F | | 4. PATIENT BIRTHDATE Month Date Year | | | 5. IF FULL TIME STUDENT School Name, City | |
| 6. SUBSCRIBER NAME AND MAILING ADDRESS ADDRESS CHANGE (Check here) <input type="checkbox"/> | | | 7. SUBSCRIBER SOCIAL SECURITY NUMBER | | 8. SUBSCRIBER BIRTHDATE Month Day Year | | | 9. EMPLOYER (Company) NAME AND ADDRESS | | 10. GROUP NUMBER |
| 11. IS PATIENT COVERED BY ANOTHER PLAN OF BENEFITS? Dental <input type="checkbox"/> Yes <input type="checkbox"/> No Medical <input type="checkbox"/> Yes <input type="checkbox"/> No | | | 12-a NAME AND ADDRESS OF CARRIER(S) | | | 12-b GROUP NUMBER(S) | | | 13. NAME AND ADDRESS OF EMPLOYER | |
| 14-a SUBSCRIBER NAME (if different than patient's) | | | 14-b SUBSCRIBER SOCIAL SECURITY NUMBER | | 14-c SUBSCRIBER BIRTHDATE Month Day Year | | | 15. RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> PARENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER | | |

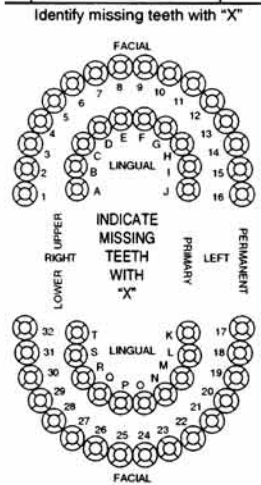
I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.

Signed (Patient or parent if minor) _____ Date _____

Signed (Insured person) _____ Date _____

| | | | | | | | | | |
|--|--|--|----|-----|-----------|--|--------------------------------|------------------------|----------------------------|
| 16. DENTIST NAME | | 24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? | | NO | YES | If yes, enter brief description and dates. | | | |
| 17. MAILING ADDRESS | | 25. IS TREATMENT RESULT OF AUTO ACCIDENT? | | | | | | | |
| CITY, STATE, ZIP | | 26. OTHER ACCIDENT? | | | | (if No, reason for replacement) | | | |
| 18. DENTIST SOC. SEC. OR T.I.N. 19. DENTIST LICENSE NO. 20. DENTIST PHONE NUMBER | | 27. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? | | | | | | | |
| 21. FIRST VISIT DATE CURRENT SERIES | 22. PLACE OF TREATMENT Office Hosp ECF Other | 23. RADIOGRAPHS OR MODELS ENCLOSED? | NO | YES | HOW MANY? | 29. IS TREATMENT FOR ORTHODONTICS? | If services already commenced: | Date appliances placed | Months treatment remaining |



| 30. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Use charting system shown. | | Date Service performed | | | Procedure number | Fee | For Administrative Use Only | |
|---|---------|---|-----|-----|------------------|-----|-----------------------------|-----------|
| Tooth # or letter | Surface | Description of service (including x-rays, prophylaxis, materials used, etc. Line No.) | Mo. | Day | | | Year | DED COPAY |
| 1. | | | | | | | | |
| 2. | | | | | | | | |
| 3. | | | | | | | | |
| 4. | | | | | | | | |
| 5. | | | | | | | | |
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| 12. | | | | | | | | |
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| 14. | | | | | | | | |
| 15. | | | | | | | | |

31. Remarks for unusual services

hereby certify that the procedure as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for these procedures.

Signed (Treating Dentist) _____ Date _____

| | |
|--------------------------|--|
| Total Fee Charged | |
| Max. Allowable | |
| Deductible | |
| Carrier pays | |
| Patient pays | |