Dental Claim Form

1. [ ] Dentist's pre-treatment estimate Specialty [ ] Dentist's statement of actual service 2. [ ] Medicaid Claim Prior Authorization # [ ] EPSOT	**Preferred Health Plan of the Carolinas** **PO Box 220397, Charlotte, NC 28222** **(866) 636-0239**
Patient Name (last, first, middle)	Address
Date of Birth (MM/DD/YYYY)	Relationship to Subscriber/Employee: [ ] Self [ ] Spouse [ ] Child [ ] Other

Employer Name	Group or Plan Number	Personal Identification Number	Daytime Phone Number

Employee Name	Address	City	State	Zip Code

Date of Birth	Martial Status	Work Status
	[ ] Single [ ] Married [ ] Divorced [ ] Widowed	[ ] Active [ ] Disabled [ ] Retired [ ] Other (specify)_____

Full Time Student? [ ] Yes [ ] No If yes, where?	Married? [ ] Yes [ ] No	I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity. X_____ _____ Signature(employee/subscriber) Date

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 of any information relating to this claim. X_____ _____ Signature Date	Did injury occur at work? [ ] Yes [ ] No

OTHER POLICIES

Is patient covered by another plan [ ] NO [ ] YES [ ] Dental [ ] Medical	Policy Number	Other Subscriber's Name	Policy No.

Date of Birth	Plan/Program Name	Employer/School Name Address

BILLING DENTIST

Name of Billing Dentist or Dental Entity	Phone Number	Provider ID No.	Dentist SS# or TIN

Address	Dentist License #	First visit date of current series:	Place of Treatment: [ ] Office [ ] Hospital [ ] Other
City	State	Zip Code	Radiographs or models enclosed? [ ] Yes, how many? [ ] No

If prosthesis (crown, bridge, denture(s)) Is this Initial placement: [ ] Yes [ ] No If no, reason for replacement: Date of prior placement:

Is treatment result of occupational illness or injury: [ ] Yes [ ] No	Is treatment result of : [ ] auto accident [ ] other accident [ ] neither Brief description and dates:

Is treatment for orthodontics? [ ] Yes [ ] No If services already commenced:
Date appliance placed: Total mos. treatment remaining:

Diagnosis Code Index (optional) 1. 2. 3. 4. 5.

Examination and treatment plans – List teeth in order

Date (mm/dd/yyyy)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee

Identify all missing teeth with X

Permanent		Primary		
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 26 25	24 23 22 21 20 19 18 17	T S R Q P	O N M L K	Payment by other plan
				Max. Allowable
Remarks for unusual services				Deductible
				Carrier %
				Carrier Pays
				Patient Pays

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

X _____
Signed (Treating Dentist) License # Date (MM/DD/YYYY

Address where treatment was preformed: _____
Address City State Zip Code