

## ATTENDING DENTIST'S STATEMENT

Check one:  Dentist's pre-treatment estimate Dentist's statement of actual services										D						Der PO	orizon Blue Cross Blue Shield of New Jersey ental Programs D Box 1311 nneapolis, MN 55440-1311									
PATIE	1. Patient name first m.i. last ☐ self ☐ spouse ☐							] child			3. Se M			Pa	tient l	birth da	te 5.	e 5. Full time stude			ent 🗌 yes 🗌 no If yes:					
ENT COVERAGE		6. Employee/subscriber name & mailing address						7. Employee/subscriber soc sec or I.D. number					nploye th date DD	)	bscriber 9. Em			oye	r (con	npany)	address	10. (	Grou	up number		
AGE -NFO		11. Is patient covered by another dental plan?  ☐ yes ☐ no If yes, complete 12-a Is patient covered by a medical plan? ☐ yes ☐ no					12-a. Name and address of ca				arrier(s) 12-b.			o. Group No.(s)					13. Name and address of other employer(s)							
RMAT-ON	14-a. Employee/subscriber name (if different than p					n pat	patient's) 14-b. Employee/s soc. sec. or l.D. r							14 c. Employee/su birth date MM DD				iber YY	15. Relationship to patient ☐ self ☐ parent ☐ spouse ☐ other							
this claim. I understand that I am responsible for all costs of dental treatment.  the below na												amed	orize payment of the dental benefits otherwise payable to me directly to med dental entity.													
	Signed (insured person)  Date  16. Name of Billing Dentist or Dental Entity									ate		24	. Is trea	Signed (insure					l) If yes, enter brief description and					date	Date	
B I L	Name of Billing Dentist of Dential Entity  17. Address where payment should be remitted												reatment result upational illness y?					, 555,	700, onto moi accomption and dates							
L I N	77. Addices where payment chould be formated											atment result ccident?														
G D	Gity, State, Zip																If no reason for replacement 120 Data of adda.						Delta de de			
E N T		18. Dentist Soc Sec or T.I.N. 19. Dentist license no. 20. Dentist phone no							·			rosthesis, is this lacement?					If no, reason for replacement 28. Date of prior placement									
i S T	21. First vişit date current series 22. Place of treatmen Office Hosp ECF			t Other	23. Radiographs or models enclosed No Yes				How many?	P 29 ort	). Is treatment for thodontics?										olianc		Mos. treatment remaining:			
Ide	er	ntify missing teeth v	with 'x'	_											ugh toot			32 – Use charting system shown. te service Procedure Fee For								
Tooth # or letter   Surface   Description of service (incompare in the service in the service)   Tooth # or letter   Description of service (incompared in the service)   Description of service (incompared in the service)   Tooth # or letter   Description of service (incompared in the service)   Tooth # or letter   Description of service (incompared in the service)   Tooth # or letter   Description of service (incompared in the service)   Tooth # or letter   Description of service (incompared in the service)   Tooth # or letter   Description of service (incompared in the service)   Tooth # or letter   Description of service (incompared in the service)   Tooth # or letter   Description of service (incompared in the service)   Tooth # or letter   Description of service (incompared in the service)   Tooth # or letter   Description of service (incompared in the service)   Tooth # or letter   Description of service (incompared in the service)   Tooth # or letter   Description of service (incompared in the service)   Tooth # or letter   Description of service (incompared in the service)   Tooth # or letter   Description of service (incompared in the service)   Tooth # or letter   Description of service (incompared in the service)   Descri						e (including x-rays			iys, propriyia			Perfo Mo. Da		rme	d Year		Procedure Number		Fee	; —	á	For administrative use only				
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31. Remarks for unusual services																										
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.  Total fee charged																										
•	s	igned (Treating De	entist)					Licens	e Numbe	er			NPI			Di	ate	_								
Cu	ıs	tomer service phor	ne numb	er – <b>1</b> (	800) 4 [	DENTA	L													Max.	allowab ctible	le		$\vdash$		
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