Attending Dentist Statement

Check one: Dentist's pre-treatment estimate Dentist's statement of actual services					Anthem Dental P O BOX 810 Minneapolis. MN 55440-0810						
P Patient Name		Relationship to Employee		Sex	Pati	Patient Birthdate		Full-	Full-Time Student Yes No		
Ť		□ Self □Child □ Spouse □Other		M F U	(MN	AIDDICCYY)			ol Name:	City:	
E Employee/subscriber name and mailing addre	SS	Employee/Subscriber ID or Soc Sec #		/Subscriber (MM DD CCY)	()	Employer (Cor	mpan	y) Name	and Address	Group/Subgroup #	
N Is patent covered by another dental plan? Name and Address of Carrier(s) F Use No				Group/Subg	roup N	Number(s)		Name	and Address	of other Employer(s)	
If yes, complete R Is patent covered by a medical plan? M □ Yes No				NY0216001D							
T Employee/Subscriber Name (if different than patient's) O N		Employee/Subscriber ID or Soc Sec #		Employee/Subscriber Birthdate (MM DD CCYY)				Relationship to Patient Self Parent Spouse 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. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement. of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.									tent to defraud any insurance or statement of claim containing any nisleading, information concerning any hich is a crime, and shall also be		
→				→ Signed (Ins	ured F	Person)				Date	
		CLAIM/TREA		NFORMATI	ON						
Place of Treatment:			sures 🗆 Yes 🛛	⊐ No							
Is Treatment for Orthodontics? Yes No					Date	Appliance Pla	ced (MIWIDD/	(CCYY)		
Months of Treatment: Replacement of Prothesis: Ves No					Date of Prior Placement (MM/DID/CCYY)						
Treatment Resulting from	_										
Occupational Illness/Injury Auto Accide Date of Accident (MM/DD/CCYY)	ent 🗆 C	Other Accident	Aut	to Accident S	tate:						
				TREATING DENTIST AND TREATMENT LOCATION INFORMATION							
claim on behalf of the patient or insured/subscriber.) Name, Address, City, State, Zip Code				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. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act,							
NPI License Number	state				hich is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the ated value of the claim for each such violation.						
Phone Number () -	Phone Number () - Additional Provider ID										
			Si							Date	
Diagnosis Code List Qualifier [ICD- 10 + AB] *Primary Diagnosis in *A" A B C D				Address, City, State, Zip Code							
A B C		D						F	Provider Spec	cialty Code	
Identify missing teeth with an "X" Examinat	tion and trea	tment plan - List in order fror	n tooth no. I	I through tooth	no. 3	2 - Use charting	g sys	tem show	vn.	For	
7 8 9 10 Tooth Letter		escription of service ncluding x-rays, prophylaxis,	sed. etc.)	Date of Service MM DD CCYY		nı	umber		administrative use only		
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2 (* 15							\vdash			_	
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²⁸ 21 27 26 35 34 ²³ 22								tal Fee			
Remarks for unusual services									1		