ATTENDING DENTIST'S STATEMENT

IMPORTANT: Please use separate copies of this form for ACTUAL SERVICES and PRE-DETERMINATION purposes.								P.O. Box 659010 Sacramento, California 95865-9010									
	☐ ACTUAL SERVICES ☐ PRE-DETERMINATION							access					Sacrame	amento, Camornia 93803-9010			
	1. Patient name	oyee	\vdash	3. Sex	4. Pati	ient t	oirthd	ate	5.	If full time stud	ent						
P	first m.i. last					□ self □ child m f □ spouse □ other			ММ	'	DD	YYY	Y	school	city		
ATIENT	Employee/subscriber name and mailing address					7. Employee/subscriber 8. Employee/subscriber birthdate			criber	iber 9. Emplo			yer (Company) 10. Group number				
ENT							MM DD YYY					YYYY					
SECT	Is patient covered by another plan of benefits? Dental					12-a. Name and address of carrier(s)			12-b.	12-b. Group no.(s)				13. Name and address of employer			
Ť	Medical	Medical															
ON.						ployee/subscriber . sec. number		14-c. Employee/subs birthdate		bscriber	criber YYYY			15. Relationship to patient ☐ self ☐ parent ☐ spouse ☐ other			
14	(if different than patient's) soc				500.			ММ									
	I lave reviewed the following treatmenthis claim. I understand that I an	I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.															
b								- <u> </u>									
H	Signed (Patient, or parent if minor) Date 16. Dentist name							Signed (Insured person) 24. Is treatment result No Yes				Yes	Date If yes, enter brief description and dates.				
DENT			of occ illnes			ccupationa ss or injur	y?										
	17. Mailing address		25. Is treatment re- of auto accider 26. Other accident			nt?	H	Н									
ST	City, State, Zip	State, Zip					2			es							
SECT	18. Dentist Soc. Sec. or T.I.N.	0.	20. Dentist phone no. 28. If prosthesis, is initial placement								29. Date of prior placement						
NO	21. First visit date current series Office	of trea		Other		adiographs or nodels enclosed?	Yes How many?			-							
	dentify missing teeth with "X"	31. Ex	31. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Use charting system she										m shown.				
	 	Tooth # or	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)						per	Date service performed Mo. Day Year			cedure mber	Fee	For administrative use only	
		letter		Line No.					1	Day	1			1			
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32	. Remarks for unusual services			13					+ ;		1	+++					
32	Helilarks for unusual services			15			1		1			1					
				7					1		1			1			
										1		1			1		
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1.5	reby certify that the procedures as indicated by date have been completed and that the fees submitted											Щ.		1 +			
are the actual fees I have charged and intend to collect for those procedures. Date												Total Fee Charged					
Sig	gned (Dentist)													Max. Allowable			
											-	Deductible Operation 9/					
													-	Carrier Carrier			
													-	Patient			