

PACIFICARE DENTAL & VISION ADMINISTRATORS
ATTENDING DENTIST'S STATEMENT AND CLAIM FORM
for predetermination of benefits and reimbursement for actual services performed

It's important to complete this form fully!
Your claim will be paid faster

JUST FOLLOW THE INSTRUCTIONS BELOW:

First, check the one box that indicates the type of claim you are filing:

If you are submitting this form for a predetermination of benefits over \$250, check the box marked DENTIST'S PRETREATMENT ESTIMATE.

If you are submitting this form in order to claim payment for services already rendered, check the box marked DENTIST'S STATEMENT OF ACTUAL SERVICES.

Then complete the entire form, following the instructions for each box number:

1. Please print or type in patient's full name: first, middle, last.
2. Place an X in the box that describes the patient's relationship with the insured employee: self, spouse, child, or other.
3. Place an X in the box that describes the patient's gender: male or female.
4. Enter the patient's birthdate: month, day, and year.
5. If the patient is a full-time student, enter the name of the school he/she attends and the city in which it is located.
6. Please enter the insured employee's name: first, middle, last.
7. Enter the insured employee's Subscriber ID Number here.
8. Enter the insured employee's full mailing address, including city, state, and zip code.
9. Enter the name of the insured dental program.
10. Enter the employer's company name and address.
11. Enter the insured employee's group number as it appears on their ID card or on the validation sticker in the front of their policy certificate.
12. Enter the city in which the employer providing coverage is located. This would be the location at which the insured employee is based.
13. Enter the name of any family member employed, other than the insured employee or the patient.
14. Enter the name and address of that family member's employer.
15. If the patient is not covered by another dental plan, enter NO. If the patient is covered by another dental plan, write YES and give the plan name, the union local (if applicable), the group number, and the name and address of the carrier providing dental coverage.
16. Enter the full name of the attending dentist.
17. Enter the attending dentist's mailing address, including city, state, and zip code.
18. Enter the attending dentist's federal tax ID number.
19. Enter the attending dentist's license number.
20. Enter the attending dentist's area code and telephone number.
21. Enter the first date on which services claimed on this form were provided.
22. Make an X in the box that best describes the place of treatment: dental office, hospital, emergency care facility, or other.
23. Are X-rays enclosed with this form? If so, mark YES and indicate how many. If not, mark NO.
24. Is the dental treatment described on this form the result of an occupational illness or injury? If not, mark NO. But if it is, mark YES and indicate the nature of the illness or injury and the date it occurred.
25. Is the dental treatment described on this form the result of an automobile accident? If not, mark NO. But if it is, mark YES and indicate the nature of the accident and the date it occurred.
26. Is the dental treatment described on this form the result of an accident of any other kind? If not, mark NO. But if it is, mark YES and indicate the nature of the accident and the date it occurred.
27. Are any of the dental services described on this form covered by another plan? If not, mark NO. But if any are, mark YES and indicate which ones.
28. If a prosthesis, such as a denture, is described in this form, is this the initial placement? If it is, mark YES. But if the prosthesis is replacing an existing appliance, mark NO and briefly indicate the reason for replacing it.
29. If you answered NO to #28, indicate the date when the prior placement occurred.
30. Are any of the dental services described in this form for orthodontic treatment? If not, mark NO. But if they are, mark YES and indicate the date when the orthodontic treatment program began and how many more months are remaining.
31. Describe the dental services this form represents. When appropriate, list them on a tooth-by-tooth basis. In numerical order, by tooth number, list:
 - Tooth Number
 - Tooth Surface
 - Name or Description of Procedure (use more than one line, if needed)
 - Date the Procedure was Performed
 - The American Dental Association (ADA) Code for the Procedure
 - The Attending Dentist's Fee for the Procedure

Refer to the full mouth chart on the left, noting tooth numbers and marking any missing teeth with an X.
32. List any additional remarks that are necessary in describing an unusual procedure or course of action.

NOTES:

- If your patient must be a full-time student to be eligible for dental benefits, please attach a current completed copy of their student verification form (if one is not currently on file with Dental Plan Administrators).

