



Independent licensees of the Blue Cross and Blue Shield Association. ® Registered Marks Blue Cross and Blue Shield Association.

Attending Dentist Statement

Check one:

- ☐ Dentist pre-treatment estimate
- ☐ Dentist statement of actual services

1. PATIENT NAME (First, Middle, Last)		2. RELATIONSHIP TO SUBSCRIBER ☐ Self ☐ Child ☐ Spouse ☐ Other		3. SEX ☐ M ☐ F		4. PATIENT BIRTHDATE Month Date Year		5. IF FULL TIME STUDENT School Name, City			
6. SUBSCRIBER NAME AND MAILING ADDRESS ADDRESS CHANGE (Check here) ☐			7. SUBSCRIBER IDENTIFICATION NUMBER		8. SUBSCRIBER BIRTHDATE Month Day Year		9. EMPLOYER (Company) NAME AND ADDRESS		10. GROUP NUMBER		
11. IS PATIENT COVERED BY ANOTHER PLAN OF BENEFITS? Dental ☐ Yes ☐ No Medical ☐ Yes ☐ No			12-a NAME AND ADDRESS OF CARRIER(S)			12-b GROUP NUMBER(S)			13. NAME AND ADDRESS OF EMPLOYER		
14-a SUBSCRIBER NAME (if different than patient's)			14-b SUBSCRIBER IDENTIFICATION NUMBER		14-c SUBSCRIBER BIRTHDATE Month Day Year			15. 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.

I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.

Signed (Patient or parent if minor)

Date _____

Signed (Insured person) _____

Date _____

DENTIST	16. DENTIST NAME						24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		NO	YES	If yes, enter brief description and dates.				
	17. MAILING ADDRESS						25. IS TREATMENT RESULT OF AUTO ACCIDENT?								
							26. OTHER ACCIDENT?								
	CITY, STATE, ZIP						27. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?				(If No, reason for replacement)				
	18. DENTIST SOC.SEC. OR T.I.N. 19. DENTIST LICENSE NO. 20. DENTIST PHONE NUMBER						28. DATE OR PRIOR PLACEMENT?								
21. FIRST VISIT DATE CURRENT SERIES		22. PLACE OF TREATMENT Office Hosp ECF Other		23. RADIOGRAPHS OR MODELS ENCLOSED?		NO	YES	HOW MANY?	29. IS TREATMENT FOR ORTHODONTICS?				If services already commenced:	Date appliances placed	Months treatment remaining

Identify missing teeth with "X"	30. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Use charting system shown.							For Administrative Use Only		
	Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc. Line No.	Date Service performed Mo. Day Year			Procedure number	Fee	DED COPAY	Benefit Amount
Diagram of a dental charting system. The upper arch (maxilla) is labeled 'UPPER' and the lower arch (mandible) is labeled 'LOWER'. The right side is labeled 'RIGHT' and the left side is labeled 'LEFT'. The diagram shows permanent teeth numbered 1 through 16 on the upper arch and 17 through 32 on the lower arch. Primary teeth are labeled with letters A through T. The diagram also includes labels for 'FACIAL', 'LINGUAL', and 'PRIMARY' surfaces. Below the diagram, it says 'INDICATE MISSING TEETH WITH "X"' and '31. Remarks for unusual services'.			1.				D			
			2.				D			
			3.				D			
			4.				D			
			5.				D			
			6.				D			
			7.				D			
			8.				D			
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			11.				D			
			12.				D			
			13.				D			
			14.				D			
			15.				D			
						D				
						D				

I hereby certify that the procedure as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for these procedures.

Signed (Treating Dentist)

Date _____

Total Fee Charged	
Max. Allowable	
Deductible	
Carrier pays	
Patient pays	