ACCESS DENTAL

CLAIM / ENCOUNTER FORM

Attending Dentist's Statement II

CHDP Patient? ◯ Yes ◯ No

Check one:

☐ **Dentist's pre-treatment estimate**

☐ **Dentist's statement of actual services**

Carrier name and address:

PATIENT SECTION

1. Patient name (first, m.i., last)
Relationship to employee: ☐ self ☐ child ☐ spouse ☐ other _____
Sex: m f
4. Patient birthdate: MM DD YYYY
5. If full time student: school city

6. Employee/subscriber name and mailing address
7. Employee/subscriber soc. sec. number
8. Employee/subscriber birthdate: MM DD YYYY
9. Employer (company) name and address
10. Group number

11. Is patient covered by another plan of benefits?
Dental _____
Medical _____
12-a. Name and address of carrier(s)
12-b. Group no.(s)
13. Name and address of employer

14-a. Employee/subscriber name (if different than patient's)
14-b. Employee/subscriber soc. sec. number
14-c. Employee/subscriber birthdate: MM DD YYYY
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.

▶ _____ Signed (Patient, or parent if minor) _____ Date

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

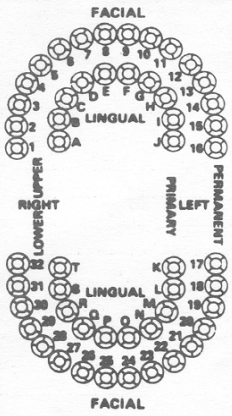
▶ _____ Signed (Insured person) _____ Date

DENTIST SECTION

16. Dentist name
17. Mailing address
City, State, Zip
18. Dentist Soc. Sec. or T.I.N.
19. Dentist license no.
20. Dentist phone no.
21. First visit date current series
22. Place of treatment: Office Hosp. ECF Other
23. Radiographs or models enclosed? No Yes How many?

	No	Yes	
24. Is treatment result of occupational illness or injury?			If yes, enter brief description and dates.
25. Is treatment result of auto accident?			
26. Other accident?			
27. Are any services covered by another plan?			
28. If prosthesis, is this initial placement?			(If no, reason for replacement) 29. Date of prior placement
30. Is treatment for orthodontics?			If services already commenced enter: Date appliances placed Mos. treatment remaining

Identify missing teeth with "x"



32. Remarks for unusual services

31. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Use charting system shown.

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	For administrative use only
		1				
		2				
		3				
		4				
		5				
		6				
		7				
		8				
		9				
		10				
		11				
		12				
		13				
		14				
		15				

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.

▶ _____ Signed (Dentist) _____ Date

Total Fee Charged	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

MAIL TO: Access Dental Plan
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