ACCESS DENTAL | PREMIER ACCESS

CLAIM / ENCOUNTER FORM

Attending Dentist's Statement II ☐ GMC ☐ HFP ☐ LAPHP ☐ DHMO CHDP Patient? ○ Yes ○ No

Check one:
☐ Dentist's pre-treatment estimate
☐ Dentist's statement of actual services
☐ Encounter

Carrier name and address:

PATIENT SECTION

1. Patient Name — First / Mi / Last
Relationship to employee: ☐ self ☐ child ☐ spouse ☐ other
Sex: M. F.
4. Patient birth date: MM DD YYYY
5. If full time student: school / city
6. Employee / Subscriber name and mailing address
7. Employee / Subscriber / CIN Soc. Sec. number
8. Employee / Subscriber birth date: 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 birth date: MM DD YYYY
15. Relationship to patient: ☐ self ☐ child ☐ spouse ☐ other

DENTIST SECTION

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**

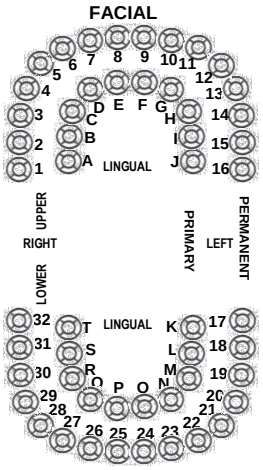
I hear by authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.

► **Signed (Insured person)** **Date**

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) prior — 29. Date of 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 hear by certify that the procedures as indicated by date have been completed and that the fee 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/Premier Access
P.O. Box 659005
Sacramento, CA 95865-9005

PHONE: LAPHP 888-414-4110
HFP 888-849-8440
GMC 916-646-2130
DHMO 866-650-3660