# Attending Dentist Statement

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

**Anthem Dental**
**P O BOX 810**
**Minneapolis. MN 55440-0810**

**PATIENT INFORMATION**

| Patient Name First / M.I. / Last | Relationship to Employee ☐ Self ☐ Child ☐ Spouse ☐ Other | Sex M \| F \| U | Patient Birthdate (MM\|DD\|CCYY) | Full-Time Student ☐ Yes ☐ No School Name: City: |
|---|---|---|---|---|
| Employee/subscriber name and mailing address | Employee/Subscriber ID or Soc Sec # | Employee/Subscriber Birthdate (MM\|DD\|CCYY) | Employer (Company) Name and Address | Group/Subgroup # |
| Is patent covered by another dental plan? ☐ Yes ☐ No If yes, complete Is patent covered by a medical plan? ☐ Yes ☐ No | Name and Address of Carrier(s) | Group/Subgroup Number(s) NY0300001D | Name and Address of other Employer(s) | |
| Employee/Subscriber Name (if different than patient's) | Employee/Subscriber ID or Soc Sec # | Employee/Subscriber Birthdate (MM\|DD\|CCYY) | 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. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement. of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

➔ _____ _____
Signed (Patient or Parent, if minor) Date

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claims for each such violation.

➔ _____ _____
Signed (Insured Person) Date

## CLAIM/TREATMENT INFORMATION

| Place of Treatment: | | Enclosures ☐ Yes ☐ No |
|---|---|---|
| **Is Treatment for Orthodontics? ☐ Yes ☐ No** | | **Date Appliance Placed (MIWIDD/CCYY)** |
| **Months of Treatment:** | **Replacement of Prothesis: ☐ Yes ☐ No** | **Date of Prior Placement (MM/DID/CCYY)** |

**Treatment Resulting from**
☐ Occupational Illness/Injury ☐ Auto Accident ☐ Other Accident

**Date of Accident (MM/DD/CCYY)** | **Auto Accident State:**

**BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

Name, Address, City, State, Zip Code

NPI | License Number | TIN or SSN

Phone Number ( ) - Additional Provider ID

Diagnosis Code List Qualifier ☐☐ (ICD- 10 + AB) *Primary Diagnosis in "A"

A _____ B _____ C _____ D _____

**TREATING DENTIST AND TREATMENT LOCATION INFORMATION**

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. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

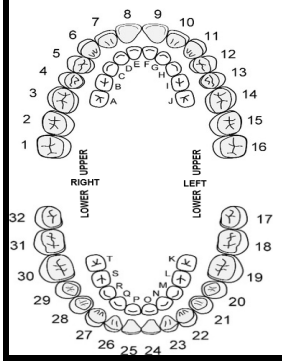
➔ _____ _____
Signed (Treating Dentist) Date

NPI | License Number

Address, City, State, Zip Code

Provider Specialty Code

**Identify missing teeth with an "X"**




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

| Tooth # or Letter | Surface | Description of service (Including x-rays, prophylaxis, materials used. etc.) | Date of Service MM \| DD \| CCYY | Procedure number D | | Fee |
|---|---|---|---|---|---|---|
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| | | | | | **Total Fee** | |

For administrative use only

Remarks for unusual services