

# ATTENDING DENTIST'S STATEMENT

**IMPORTANT: Please use separate copies of this form for ACTUAL SERVICES and PRE-DETERMINATION purposes.**



P.O. Box 659010  
Sacramento, California 95865-9010

- ACTUAL SERVICES  
 PRE-DETERMINATION

P A T I E N T  S E C T I O N	1. Patient name first m.i. last	2. Relationship to employee <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse <input type="checkbox"/> other _____	3. 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)   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 <input type="checkbox"/> self <input type="checkbox"/> parent <input type="checkbox"/> spouse <input type="checkbox"/> 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 \_\_\_\_\_

D E N T I S T  S E C T I O N	16. Dentist name	24. Is treatment result of occupational illness or injury? No   Yes   If yes, enter brief description and dates.	
	17. Mailing address City, State, Zip	25. Is treatment result of auto accident? 26. Other accident?	
	18. Dentist Soc. Sec. or T.I.N.   19. Dentist license no.   20. Dentist phone no.	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	
	21. First visit date current series	22. Place of treatment Office   Hosp.   ECF   Other	23. Radiographs or models enclosed?   No   Yes   How many?

Identify missing teeth with "X"  	31. 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
			1						
			2						
			3						
			4						
			5						
			6						
			7						
			8						
			9						
			10						
			11						
			12						
			13						
			14						
		15							
32. Remarks for unusual services									

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	