ATTENDING DENTIST'S STATEMENT

Please Mail Claims to:
P.O. Box 6560 • Sherwood, AR 72124

Customer Service:
877-999-2330

CHECK ONE: ☐ FOR PREDETERMINATION ☐ FOR PAYMENT

PATIENT SECTION

1. PATIENT NAME
2. RELATIONSHIP TO MEMBER — SELF ☐ SPOUSE ☐ DGHTR ☐ SON ☐
3. OTHER ☐ M ☐ F
4. PATIENT BIRTHDATE — MO | DAY | YEAR
5. STUDENT INFORMATION — ☐ FULL TIME ☐ PART-TIME SCHOOL
6. EMPLOYEE/SUBSCRIBER NAME — FIRST MIDDLE LAST
7. EMPLOYEE/SUBSCRIBER ID
9. NAME OF GROUP DENTAL PROGRAM
8. EMPLOYEE/SUBSCRIBER MAILING ADDRESS — TELEPHONE NUMBER
CITY, STATE, ZIP
10. EMPLOYER (COMPANY) NAME AND ADDRESS
11. GROUP NUMBER
12. LOCATION (LOCAL)
13. ARE OTHER FAMILY MEMBERS EMPLOYED? EMPLOYEE NAME — I.D. NO. — BIRTH DATE
14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13.
15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? — DENTAL PLAN NAME — UNION LOCAL — GROUP NO. — NAME AND ADDRESS OF CARRIER

DENTIST SECTION

16. BILLING DENTIST/ENTITY
17. MAILING ADDRESS
CITY, STATE, ZIP
18. Tax Identification No.
19. Dentist License No.
20. National Provider ID
21. Dentist Phone No.
22. FIRST VISIT DATE CURRENT SERIES
23. PLACE OF TREATMENT — OFFICE | HOSP. | ECF | OTHER
24. RADIOGRAPHS OR MODELS ENCLOSED? **ATTACH X-RAYS SECURELY** — NO | YES | HOW MANY?

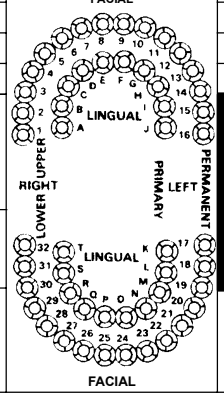
	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
25. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
26. IS TREATMENT RESULT OF AUTO ACCIDENT?			
27. OTHER ACCIDENT?			
28. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
29. IF PROSTHESIS OR SINGLE CROWN(S), IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) — 30. DATE OF PRIOR PLACEMENT
31. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED, ENTER — DATE APPLIANCE PLACED — MOS. TREATMENT REMAINING

DESCRIPTION	TOOTH # OR LETTER	SURFACE	DATE SERVICE PERFORMED MO. DAY YEAR	PROCEDURE NUMBER	FEE	DESCRIPTION OF SERVICE	TOOTH # OR LETTER	SURFACE	DATE SERVICE PERFORMED MO. DAY YEAR	PROCEDURE NUMBER	FEE

32. REMARKS FOR UNUSUAL SERVICES

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

IDENTIFY MISSING TEETH WITH "X"



TOTAL FEES

I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials **not paid** by my dental benefit plan. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

Signature on File

SIGNED (PATIENT, OR PARENT IF MINOR) DATE

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named entity.

Signature on File

SIGNED (EMPLOYEE/SUBSCRIBER) DATE

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 (TREATING DENTIST) LICENSE NUMBER DATE

MAIL ORIGINAL TO PLAN, **RETAIN** COPY FOR YOUR FILE.
Form Number OME-01