

EMPLOYEE/SUBSCRIBER MUST COMPLETE SECTIONS 1-17

1. PATIENT NAME		2. RELATIONSHIP TO SUBSCRIBER SELF SPOUSE CHILD OTHER				3. SEX M F		4. PATIENT BIRTHDATE MO. DAY YEAR			5. IF CHILD AGE 19 OR OVER, NAME OF SCHOOL		FULL TIME STUDENT: NO <input type="checkbox"/> YES <input type="checkbox"/>	
6. SUBSCRIBER FIRST		MIDDLE		LAST		7. SUBSCRIBER IDENTIFICATION NO				8. NAME OF EMPLOYER				
10. SUBSCRIBER MAILING ADDRESS												9. GROUP NUMBER		
11. CITY, STATE, ZIP														
12. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? NO <input type="checkbox"/> YES <input type="checkbox"/> IF YES: →		13. EMPLOYEE NAME AND BIRTHDATE				14. SUBSCRIBER ID NO.				15. EMPLOYER NAME				
		16. NAME AND ADDRESS OF CARRIER				17. GROUP NO.								
NAME OF DENTIST OR DENTAL ENTITY		TAX ID OR SOC. SEC. NO.				IS TREATMENT RESULT OF ACCIDENT? NO <input type="checkbox"/> YES <input type="checkbox"/> IF YES, DATE				IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY NO <input type="checkbox"/> YES <input type="checkbox"/>				
MAILING ADDRESS		LICENSE NO.				RADIOGRAPHS OR MODELS ENCLOSED? NO <input type="checkbox"/> YES <input type="checkbox"/> HOW MANY?				IF PROSTHESIS: IS THIS INITIAL PLACEMENT? NO <input type="checkbox"/> YES <input type="checkbox"/> IF NO, ENTER REASON FOR REPLACEMENT AND DATE OF PLACEMENT IN REMARKS BELOW				
CITY STATE, ZIP		TELEPHONE NO.				IS TREATMENT FOR ORTHODONTICS? NO <input type="checkbox"/> YES <input type="checkbox"/> IF SERVICES ALREADY COMMENCED ENTER DATE APPLIANCE PLACED: MONTHS TREATMENT REMAINING:								

DESCRIPTION	TOOTH	SURFACES	DATE	ADA CODE	FEE	DESCRIPTION	TOOTH	SURFACES	DATE	ADA CODE	FEE
Periodic Exam				D0120		Extraction				D7140	
Limited Oral Eval				D0140		Extraction				D7140	
Comp Series-BW				D0210		Extraction				D7140	
Periapical 1 st film				D0220							
Periapical EA Add ()				D0230							
1-BW-X-Ray				D0270							
2-BW-X-Ray				D0272							
4-BW-X-Ray				D0274							
Panoramic Film				D0330							
Prophy – Adult				D1110							
Prophy – Child				D1120							
Fluoride – Child				D1203							
Sealant				D1351							
Amalgam 1SF				D2140							
Amalgam 1SF				D2140							
Amalgam 1SF				D2140							
Amalgam 2SF				D2150							
Amalgam 2SF				D2150							
Amalgam 3SF				D2160							
Amalgam 3SF				D2160							
Amalgam 4SF				D2161							
Comp 1SF (Ant)				D2330		TOTAL FEE CHARGED					
Comp 1SF (Ant)				D2330							
Comp 1SF (Ant)				D2330		ANY SERVICE EXCEEDING \$250.00 SHOULD BE PRE-DETERMINED CLAIM MUST BE FILED WITHIN ONE YEAR OF DATE OF SERVICE					
Comp 2SF (Ant)				D2331		REMARKS FOR UNUSUAL SERVICES					
Comp 3SF (Ant)				D2332							
Comp 1SF (Post)				D2391		II HEREBY AUTHORIZE PAYMENT OF THE DENTIST BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THE BELOW NAMED DENTAL ENTITY.					
Comp 1SF (Post)				D2391		SIGNED (EMPLOYEE/SUBSCRIBER) _____ DATE _____					
Comp 1SF (Post)				D2391		I ACCEPT THIS ATTENDING DENTIST'S STATEMENT AND AUTHORIZE RELEASE OF INFORMATION RELATING HERETO.					
Comp 2SF (Post)				D2392		I CERTIFY THE TRUTH OF PERSONAL INFORMATION CONTAINED ABOVE.					
Comp 3SF (Post)				D2393		I AGREE TO BE RESPONSIBLE FOR PAYMENT FOR SERVICES PROVIDED DURING ANY INELIGIBLE PERIOD.					
Pulpotomy				D3220		PATIENT (PARENT OR EMPLOYEE) SIGNATURE <input checked="" type="checkbox"/> _____ DATE _____					
RCT-Ant				D3310		(TREATMENT COMPLETED-PAYMENT REQUESTED)					
RCT-Bicsp				D3320		THE TREATMENT LISTED WAS COMPLETED AND WAS NECESSARY IN MY PROFESSIONAL JUDGEMENT. I REQUEST PAYMENT IN ACCORDANCE WITH DDVA PARTICIPATING DENTIST RULES.					
RCT-Molar				D3330		DENTIST SIGNATURE <input checked="" type="checkbox"/> _____ DATE _____					
Perio Scal/Rt Plan				D4341		(PREDETERMINATION OF COST)					
Perio Maint				D4910		THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGEMENT AND I REQUEST AUTHORIZATION IN ACCORDANCE WITH DDVA PARTICIPATING DENTIST RULES.					
						DENTIST SIGNATURE <input checked="" type="checkbox"/> _____ DATE _____					