

**Dental Claim Form**

1. -Dentist's pretreatment estimate \_\_\_\_\_  
-Dentist's statement of actual services provider ID # \_\_\_\_\_
2. -Medicaid Claim \_\_\_\_\_ EPSDT \_\_\_\_\_  
-Prior Authorization # \_\_\_\_\_  
-Patient ID# \_\_\_\_\_
3. -Carrier name and address \_\_\_\_\_  
\_\_\_\_\_
4. -Patient name (first, middle, last) \_\_\_\_\_  
\_\_\_\_\_
5. -Relationship to employee  
-self \_\_\_ -spouse \_\_\_ -child \_\_\_ -other \_\_\_\_\_
6. -Sex- male \_\_\_ Female \_\_\_
7. -Patient Birth date MM \_\_\_ DD \_\_\_ YY \_\_\_
8. -If full time student School \_\_\_\_\_ City \_\_\_\_\_
9. -Employee subscriber and mailing address \_\_\_\_\_  
\_\_\_\_\_
10. -Employee/subscriber dental plan I.D. number \_\_\_\_\_
11. -Employee/subscriber birth date MM \_\_\_ DD \_\_\_ YY \_\_\_\_\_
12. -Employer (company) name and address \_\_\_\_\_  
\_\_\_\_\_
13. -Group number \_\_\_\_\_
14. -Is patient covered by another dental plan yes \_\_\_ no \_\_\_  
If yes complete 15. Is patient covered by a medical plan? Yes \_\_\_ no \_\_\_
15. -Name and address of carrier(s) along with group number of the policy \_\_\_\_\_  
\_\_\_\_\_  
Group no. (s) \_\_\_\_\_
16. -Name and address of other employers(s) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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17-a. -Employee/subscriber name (if different from patient's)

\_\_\_\_\_

17-b.-Employee/subscriber dental plan I.D. number

\_\_\_\_\_

17-c.-Employee/subscriber birth date MM \_\_\_\_\_ DD \_\_\_\_\_ YY \_\_\_\_\_

18. -Relationship to patient

-self \_\_\_\_\_ -spouse \_\_\_\_\_ -child \_\_\_\_\_ -other \_\_\_\_\_

19. I have read the following treatment plan and fees.  
I agree to be responsible for all charges for dental services and materials not paid by my dental benefits plan. Unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under a applicable law. I authorize release of any information relating to this claim form.

\_\_\_\_\_  
Signed (Patient or guardian)

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Signed (Employee/subscriber)

\_\_\_\_\_  
Date