CareFirst Administrators

ATTENDING DENTIST'S STATEMENT

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

Please refer to your identification card for mailing instructions.

PATIENT COVERAGE

1. Patient Name — First / M.I. / Last
2. Relationship to Insured — ☐ Self ☐ Child ☐ Spouse ☐ Other
3. Sex — M F
4. Patient Birthdate — MM DD YYYY
5. If full-time student — School / City
6. Employee Name and Mailing Address
6. Employee Social Security Number
8. Employee Birthdate — MM DD YYYY
9. Employer (company) Name and Address
10. Group Number
11. Is patient covered by another dental plan? If yes, complete 12-15. Yes ☐ No ☐
Is patient covered by a medical plan? Yes ☐ No ☐
12-A. Name and Address of Carrier(s)
12-B. Group No(s)
13. Name and Address of Employer
14-A. Employee Name (If different than patient's)
14-B. Employee Social Security Number
14-C. Employee Birthdate — MM DD YYYY
15. Relationship to insured — ☐ Self ☐ Child ☐ 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.

Signed (Patient, or parent if minor)

I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.

Signed (Insured Person)

BILLING DENTIST

16. Name of the Billing Dentist of Dental Entity
17. Address of where payment should be remitted.
City, State, Zip
18. Dentist Social Security or T.I.N.
19. Dentist License No.
20. Dentist Phone No.
21. First visit date current series — 22. Place of Treatment Office Hosp. ECF Other
23. Radiographs — No ☐ Yes ☐ How Many?
24. Is treatment result of occupational illness or injury? — No ☐ Yes ☐ If yes, enter brief description and dates.
25. Auto accident? — No ☐ Yes ☐
26. Other accident? — No ☐ Yes ☐
27. If prosthesis, is this initial replacement? — No ☐ Yes ☐ If no, reason for replacement
28. Date of prior placement
29. Is treatment for orthodontics? — No ☐ Yes ☐ If services already commenced, enter: Date appliance placed / Mos. treatment remaining

30. Examination and treatment plan: List in order from tooth No. 1 through tooth No. 32

No. or Letter	Surface	Description of service (Include x-rays, prophylaxis, materials, etc.) Line No.	Dates of service performed MM	DD	YYYY	Procedure Number	Fee		For administrative use only

31. 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.

(Treating Dentist Signature) License Number Date

Total Fee Charged	
Max allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	