Dental Claim Form

See reverse for instructions

1. ☐ **Dentist's pre-treatment estimate**	2. ☐ **Dentist's statement of actual services**	3. Carrier name and address NATIONAL PACIFIC DENTAL 1445 NORTH LOOP WEST, SUITE 500 HOUSTON, TX 77008

PATIENT COVERAGE INFORMATION

4. Patient name first m.i. last	5. Relationship to employee ☐ self ☐ child ☐ spouse ☐ other _____	6. Sex m f	7. Patient birthdate MM DD YYYY	8. If full time student school
9. Employee/subscriber name and mailing address	10. Employee/subscriber dental plan I.D. number	11. Employee/subscriber birthdate MM DD YYYY	12. Employer (company) name and address	13. Group number
14. Is patient covered by another dental plan? yes no If yes, complete 15-a. Is patient covered by a medical plan? yes no	15-a. Name and address of carrier(s)	15-b. Group no.(s)	16. Name and address of other employer(s)	
17-a. Employee/subscriber name (if different from patient's)	17-b. Employee/subscriber dental plan I.D. number	17-c. Employee/subscriber birthdate MM DD YYYY	18. Relationship to patient ☐ self ☐ patient ☐ spouse ☐ other _____	

19. 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 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 applicable law, I authorize release of any information relating to this claim.

> _____
Signed (Patient – see reverse) Date

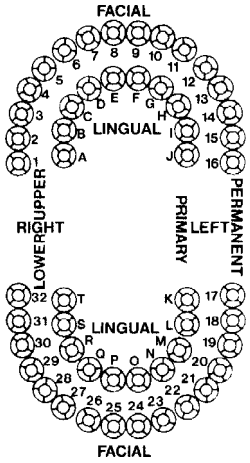
20. I hereby authorize payment of the dentist benefits otherwise payable to me directly to the below named dental entity.

> _____
Signed (Employee/subscriber) Date

BILLING DENTIST

21. Name of Billing Dentist of Dental Entity	30. Is treatment result of occupational illness or injury?	No	Yes	If yes, enter brief description and dates.	
22. Address where payment should be remitted	31. Is treatment result of auto accident?				
23. City, State, Zip	32. Other accident?			/ /	
24. Dentist Soc. Sec, or T.I.N. (see reverse)	25. Dentist license no.	26. Dentist phone no,	33. If prosthesis, is this initial placement?		(If no, reason for replacement)	34. Date of prior placement.
27. First visit date current series / /	28. Place of treatment Office Hosp. ECF Other	29. Radiographs or models enclosed? ☐ No ☐ Yes	29a. Return? ☐ No ☐ Yes	35. Is treatment for orthodontics?	If service already commenced enter.	Date appliances placed / /	Max. treatment remaining

36. Identify missing teeth with "x"



37. Examination and treatment plan – List in order from tooth no. 1 through tooth no. 32 – Using charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year	Procedure number	Fee	For administrative use only

38. Remarks for unusual services.

39. 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

40. Address where treatment was performed

City State Zip

41. Total Fee Charged	
42. Payment by other plan	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

SPD-1107