Dental Claim Form

SECURECARE DENTAL

1. ☐ Dentist's pre-treatment estimate
☐ Dentist's statement of actual services
Provider ID #

2. ☐ Medicaid Claim
☐ EPSDT
PriorAuthorization #
Patient ID #

3. Carrier name and address
SecureCare Dental, Inc.
3625 North 16th Street, Suite 206
Phoenix, AZ 85016

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 city

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 than patient's)

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

17-c. Employee/subscriber birthdate MM DD YYYY

18. Relationship to patient ☐ self ☐ parent ☐ 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 any dental benefit 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 the claim.**

Signed (Patient, or parent if minor) Date

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

Signed (Employer/Subscriber) Date

BILLING DENTIST

21. Name of Billing Dentist or Dental Entity

22. Address where payment should be remitted

23. City, State, Zip

24. Dentist Soc. Sec. or T.I.N.

25. Dentist license no.

26. Dentist phone no.

27. First visit date current series

28. Place of treatment Office Hosp. ECF Other

29. Radiographs or models enclosed? No Yes How many?

30. Is treatment result of occupational illness or injury? No Yes If yes, enter brief description and dates.

31. Is treatment result of auto accident?

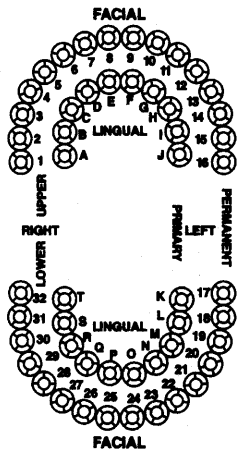
32. Other accident?

33. If prosthesis, is this initial placement? (If no, reason for replacement)

34. Date of prior placement

35. Is treatment for orthodontics? If services already commenced enter: Date appliances placed Mos. 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	

Item 24547
ADA 1995 VERSION