# ATTENDING DENTIST'S STATEMENT

**UNITED CONCORDIA**

America's Premier Dental Insurer

Check One

- ❑ Dentist's pre-treatment estimate
- ❑ Dentist's statement of actual services

**Please submit claim to:** Dental Claims
P.O. Box 69421
Harrisburg, PA 17106-9421

## PATIENT SECTION

1. Patient name

2. Relationship to employee: self | spouse | child | other

3. Sex: m | f

4. Patient birthdate: mo | day | year

5. If full time student: school | city

6. Employee/subscriber name: First | middle | last

9. Contract ID # or SSN

8. Employee/subscriber mailing address

City, State, Zip

10. Employer (company) name and address

11. Group Number

12. Location (Local)

13. Are other family members employed? Employee name | Soc. sec. no.

14. Name and address of employer in item 13

15. Is patient covered by another dental plan? | Dental plan name | Union local | Group no. | Name and address of carrier

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.

Signature (patient or parent if minor) | Date

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

Signature (insured person) | Date

## DENTIST SECTION

16. Dentist name

17. Mailing address

City, state, zip

18. Dentist soc. sec. or T.I.N.

19. Dentist license no.

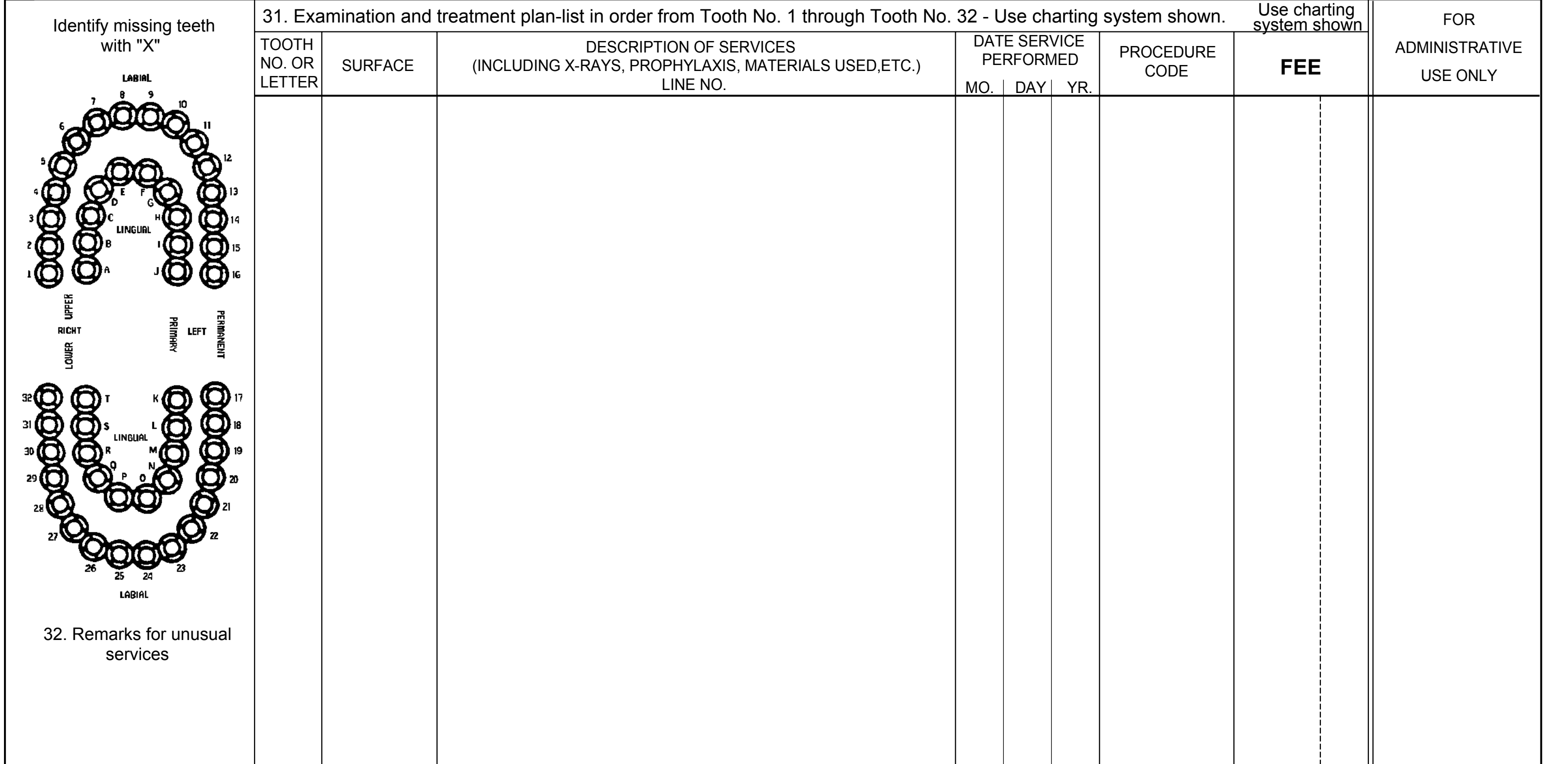
20. Dentist phone no.

21. First visit date current series

22. Place of treatment: Office | Hosp. | ECF | Other

23. Radiographs or models enclosed? No | Yes | How Many?

| | No | Yes | If yes, enter brief description and dates |
|---|---|---|---|
| 24. Is treatment result of occupational illness or injury? | | | |
| 25. Is treatment result of auto accident? | | | |
| 26. Other accident? | | | |
| 27. Are any services covered by another plan? | | | |
| **28. If prosthesis, is this initial placement?** | | | **(If no, reason for replacement)** **29. Date of prior placement** |
| 30. Is treatment for orthodontics? | | | If services already commenced enter: Date appliances placed \| Mos. treatment remaining |



Identify missing teeth with "X"



31. Examination and treatment plan-list in order from Tooth No. 1 through Tooth No. 32 - Use charting system shown.

| TOOTH NO. OR LETTER | SURFACE | DESCRIPTION OF SERVICES (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED,ETC.) LINE NO. | DATE SERVICE PERFORMED MO. | DAY | YR. | PROCEDURE CODE | FEE | FOR ADMINISTRATIVE USE ONLY |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

32. 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.

Signature (Dentist) ______________________ Date ______________

| | |
|---|---|
| **TOTAL FEE CHARGED** | |
| MAX ALLOWABLE | |
| DEDUCTIBLE | |
| CARRIER % | |
| CARRIER PAYS | |
| PATIENT PAYS | |

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties. The signer hereby authorizes any insurer, employer, organization or health care service provider to release to the plan all information relating to past, present and future health care examinations or treatments received by each person covered by this claim/application.

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