Attending Dentist's Statement

Check one:

☐ **Dentist's pre-treatment estimate**

☐ **Dentist's statement of actual services**

DENTAL CLAIM FORM

STANDARD FORM AND INSTRUCTIONS ARE ON BACK

AMWINS™
CONNECT ADMINISTRATORS
(800)337-4973

PATIENT SECTION

1. Patient Name (first, m.i., last)	2. Relationship to employee (☐ self ☐ spouse ☐ child ☐ other)	3. Sex (m f)	4. Patient birth date (MM DD YYYY)	5. If full time student (school, city)

6. Employee/subscriber name and mailing address	7. Employee/subscriber Identification number	8. Employee/subscriber birth date (MM DD YYYY)	9. Employer (company) name and address	10. Group number

11. Is patient covered by another plan of benefits? (Dental / Medical)	12-a. Name and address of carrier(s)	12-b. Group no.(s)	13. Name and address of employer

14-a. Employee/subscriber name (if different than patient's)	14-b. Employee/subscriber identification number	14-c. Employee/subscriber birth date (MM DD YYYY)	15. Relationship to patient (☐ self ☐ spouse ☐ child ☐ other)

16. **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) _____ Date

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

▶ _____ Signed (Insured person) _____ Date

DENTIST SECTION

18. Dentist name	26. Is treatment result of occupational illness or injury?	No	Yes	If yes, enter brief description and dates
19. Mailing address	27. Is treatment result of auto accident?			
	28. Other accident?			
City. State, Zip	29. Are any services covered by another plan?			

20. Dentist Soc. Sec or T.I.N.	21. Dentist license no.	21. Dentist phone no.	30. If prosthesis. is this the initial placement?			If no, reason for replacement	31. Date of Prior Placement

23. First visit date current series	24. Place of treatment (Office Hosp ECF Other)	25. Radiographs or models enclosed?	No	Yes	How many?	32. Is treatment for orthodontics?			Down payment amount	Date appliances placed	Monthly payment amount

33. What amount has patient paid	34. Circled fees / todays charges	35.
$	$	☐ PRE TREATMENT ESTIMATE $

DIAGNOSTIC

SERVICE DATE			FEE
		D0150 ORAL EXAM	
		D0120 ORAL EXAM	
		D0130 EMERGENCY EXAM	
		D0210 FULL SERIES/INC. B.W.	
		D0220 SINGLE FIRST X-RAY	
		D0230 ADDITIONAL # _____	
		D0270 BITEWING X-RAY	
		D027 _ ADDITIONAL # _____	
		D0330 PANOREX/INC. B.W.	
		D0470 DIAGNOSTIC MODELS	

PREVENTATIVE

		D1110 ADULT ___ D1120 CHILD	
		D12__ FLUORIDE	

AMALGAM RESTORATIONS

	TOOTH	SURFACES		
		D21__		
		D21__		
		D21__		
		D21__		
		D21__		
		D21__		
		D219_ PIN RETENTION		

COMPOSITE RESTORATIONS

		SURFACES		
		D23__		
		D23__		
		D23__		
		D23__		
		D2951_ PIN RETENTION		

PROSTHETICS

SERVICE DATE			FEE
		COMPLETE	
		D5110 UPPER DENTURE	
		D5120 LOWER DENTURE	
		IMMEDIATE	
		D5130 UPPER DENTURE	
		D0220 LOWER DENTURE	
		PARTIALS	
		D52__ UPPER _____	
		D52__ LOWER _____	
		D56__ DENTURE REPAIR # _____	
		D0470 RELINE _____U _____L	
		***PERIODONTICS**	
		D4210 GINVEVECTOMY	
		AREA	
		D4220 CURETTAGE	
		AREA	
		D4260 OSSEOUS SURGERY	
		AREA	
		D4341 SCALING/ROOT PLANE	
		AREA	
		D4355 DEBRIDEMENT	
		D4381 ANTIMICROBIAL AGENTS	
		D4910 PERIODONTAL PROPHY	
		D9220 **GENERAL ANESTHESIA**	
		TIME	
		D9110 PALLIATIVE TREATMENT	
		TOOTH #	
		OTHER	

ENDODONTICS

SERVICE DATE	TOOTH		FEE
		D3110 PULP CAP DIRECT	
		D3220 PULPOTOMY	
		ROOT CANAL	
		D3310 ANTERIOR	
		D3320 BICUSPID	
		D3330 MOLAR	
		EXTRACTIONS	
		D7110 SIMPLE	
		D7120 EACH ADDL.	
		# _____	
		D7210 ERUPTED TOOTH	
		IMPACTIONS	
		D7220 SOFT TISSUE	
		D7230 PARTIAL BONY	
		D7240 FULL BONY	
		D7241 COMPLICATED *	
		CROWNS (INDIVIDUAL)	
		D27__ _____	
		D27__ _____	
		D27__ _____	
		D27__ _____	
		D27__ _____	
		D2920 REPLACMENT CROWN	
		D2950 PIN BLD. UP	
		D2952 _____POST & CORE	
		***FIXED BRIDGE**	
		D6___ _____	
		D6___ _____	
		D6___ _____	
		D6930 REPLACEMENT BRIDGE	
		D6970 ____POST & CORE	

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 (Dentist) _____ Date

***SUBJECT TO SUBMISSION OF TREATMENT PLAN & X-RAYS**

INSTRUCTIONS

HOW TO FILE A CLAIM

Complete questions 1 through 15 and sign on line 16.

Ask your dentist to complete the claim form after examination. The dentist should show the full treatment plan.

PREDETERMINATION

If a course of treatment can reasonably be expected to be less than $300, the form can be submitted when treatment is completed.

If a course of treatment can reasonably be expected to be $300 or more, follow these steps.

a. Complete questions 1 through 15.

b. Give the claim form to your dentist.

c. Have your dentist complete his section of the claim form, showing a description of the procedures to be performed and the proposed fees. Your dentist should submit the completed form, with x-rays to Amwins Connect Administrators at the address below.

d. Amwins Connect Administrators will review the description of the procedures to be performed and the charges, and will notify you and your dentist of the benefit payable.

e. After the dentist completes the work, he should indicate on the claim form the specific services performed, dates of service, and the charges. Your dentist should send the complete claim form to Amwins Connect Administrators at the address below.

X-Rays must be submitted with the claim form whenever the charge for the treatment plan is more than $300.

TO WHOM ARE BENEFITS PAID?

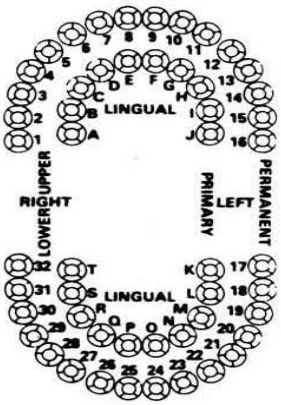
You can arrange for Amwins Connect Administrators to make payment directly to the dentist by signing on line 17. If you want the benefits paid directly to you, do not sign on line 17. In either case, a statement of benefits paid will be sent to you.

Claim forms and questions should be directed to:

Amwins Connect Administrators
Attention: Claims Department
P.O. Box 4368
Lutherville, MD 21094-9998
Toll Free: 800.337.4973
Fax Number: 410.584.9467
gbs.claims@amwins.com

IDENTIFY MISSING TEETH WITH "X"

FACIAL



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	TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE	DATE SERVICE PERFORMED MO	DAY	YEAR	PROCEDURE NUMBER	FEE	PLAN USE