HIGHMARK. Delaware

CONTROL NUMBER

ATTENDING DENTIST'S STATEMENT

Check one box only: ❑ Pre-treatment Estimate ❑ Statement of Actual Services

Patient's Account # _____

CUSTOMER SECTION

1. Patient's Name (First, Initial, Last)	2. Relationship to Employee self / spouse / child / other	3. Sex m / f	4. Patient Birth Date mo / day / year	5. If a full time student: school / city
6. Employee's / Member's Name	7. Employee's / Member's Social Security Number			8. Name of Group Dental Program
9. Employee's / Member's Mailing Address (Street, City, State, Zip Code)		10. Employee's / Group's Name and Address		
11. Group Number	12. Member's ID Number	13. Are other family members employed? If Yes: Employee's Name: Social Security Number:		14. Name and Address of Employer in Item # 13
15. Is patient covered by another dental plan? ❑ Yes ❑ No	Dental Plan Name	Union Local	Group Number	Name and Address of Carrier

DENTIST SECTION

16. Dentist's Name and Highmark BCBS DE Payment Code			24. Is treatment result of occupational illness / injury?	No	Yes	If Yes, enter brief description and dates:	
17. Dentist's Mailing Address (Street, City, State, Zip Code)			25. Is treatment result of an auto accident?				
			26. Other accident?				
			27. Are any services covered by another plan?				
18. Soc. Sec. No. or T.I.N.	19. License No.	20. Dentist's Phone No.	28. If prosthesis, is this initial placement?			If No, reason for replacement:	29. Date of Prior Placement / /
21. First Visit Date Current Series / /	22. Place of Treatment Office / Hosp. / SNF / Other	23. Radiographs or Models enclosed? ❑ Yes ❑ No How many?	30. Is treatment for Orthodontics?			If services already commenced, enter:	Date Appliances Placed / / Mos. treatment remaining

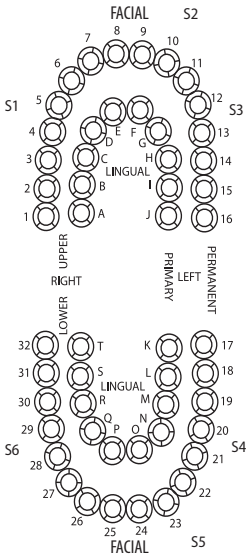
DENTIST'S STATEMENT: I hereby certify that the services listed have been or will be provided by me.

Dentist's Signature: **Date:**

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a claim containing false, incomplete or misleading information may be guilty of a felony.

31. Examination and Treatment Plan: List in order from Tooth No. 1 through Tooth No. 32. Use charting system shown.

Identify missing teeth with an "X"



TOOTH NO. OR LETTER	SURFACE	DESCRIPTION OF SERVICES (X-Rays, Prophylaxis, Materials, etc.)	DATE OF SERVICE MO.	DAY	YR.	PROC CODE	FEE	FOR BLUE CROSS BLUE SHIELD USE ONLY #	RIDER	DISP	REF.	ALLOWANCE	COMMENTS
						TOTAL FEE				TOTAL ALLOWANCE			

FOR HIGHMARK BLUE CROSS BLUE SHIELD DELAWARE USE ONLY

Type Transaction	Group Number	Type Contract	Type Provider	Payee	COB	Hospital Code	Place of Treatment	Processor Number

1. Predetermination **2.** Claim **3.** Refusal **4.** Correction **5.** Manual

L. In-Par **P.** In Non-Par **X.** Out

1. Inpatient **2.** Outpatient **3.** Office

Please return claim to: Highmark Blue Cross Blue Shield Delaware • P.O. Box 8829 • Wilmington, DE 19899-8829

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