1 Type of Transportion (Mark -III				tal Claim												
Type of Transaction (Mark all applicable boxes) Statement of Actual Services Request for Predetermination/Preauthorization																
EPSDT / Title XIX																
2. Predetermination/Preauthoriza	POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3) 12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code															
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OTHER COVERAGE (Mark a	16. Plan/Group Number 17. Employer Name															
4. Dental? Medical?																
Name of Policyholder/Subscrib	PATIENT INFORMATION															
the setting processing	denue	an part as	in the distriction of	o do ellimen	N STIFF	18	8. Relationshi	p to Polic	yholder/Su	bscriber in #	12 Above	9, 14 (0.16		ved For Future		
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (Assigned by Pla							an) Self Spouse Dependent Child Other									
M F U						20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code										
9. Plan/Group Number 10. Patient's Relationship to Person named in #5																
		Self Spouse Dependent Other														
11. Other Insurance Company/De	ental Ber	nefit Plan Na	ame, Address, City, Sta	nte, Zip Code	CHEFF											
						19										
						21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assigned by Den								signed by Dentist)		
RECORD OF SERVICES P	POVID	ED		Manufacture and			Name of the last						profession de la Co	de municipa		
35		26	CONTICINATION TO THE	A CONTRACTOR OF THE PARTY OF TH	1011111	ny mana				and another terms	The second	nd karana	Ole and our ed			
Z4. Procedure Date of	Oral To	ooth	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Proce Code		29a. Diag. Pointer	29b. Qty.			30. Desc	ription		31. Fee		
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33. Missing Teeth Information (PI	ace an "	X" on each r	missing tooth.)	34. D	iagnosis	Code	List Qualifier		(ICD-10	= AB)		YT DE	31a. Other	14738141		
1 2 3 4 5 6	6 7 8 9 10 11 12 13 14 15 16 34a. Diagno					s Code(s) A C						ree(s)	Se mill?			
32 31 30 29 28 27	26 25	5 24 23	22 21 20 19	18 17 (Prim	ary diag	nosis i	in "A")	В	sails i	D_		named to	32. Total Fee	teligrad 1		
35. Remarks																
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AUTHORIZATIONS						ANC	CILLARY C	LAIM/T	REATME	NT INFO	RMATIC	N				
36. I have been informed of the tr						38. P	Place of Treati	ment	(e.g. 1	1=office; 22=0	D/P Hospit	tal) 39. En	closures (Y or N)	ĺ		
charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all							(Use "Place of Service Codes for Professional Claims")									
or a portion of such charges. of my protected health informa-						40. Is	s Treatment f	or Orthod	ontics?	urië an in ive	Boarus	41. Date	Appliance Place	d (MM/DD/CCYY		
of my protected health information to carry out payment activities in connection with this claim.								ip 41-42)	Yes	(Complete 4	11-42)	-				
Patient/Guardian Signature Date							Months of Trea	atment	43. Repla	acement of P	rosthesis	44. Date	of Prior Placeme	nt (MM/DD/CCYY		
37. I hereby authorize and direct	naumon	t of the deat	al hanofite athonyica n	avable to me, dire	othy				No	Yes (Cor	mplete 44	1)				
to the below named dentist o			ai belielits otilei wise p	ayable to me, dire	City	45. Ti	reatment Res	sulting fro	m							
V THE								Occupational illness/injury Auto accident Other accident								
Subscriber Signature Date							46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State									
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not							TREATING DENTIST AND TREATMENT LOCATION INFORMATION									
submitting claim on behalf of the				To har office to five								Control of the Contro	ess (for procedu	res that require		
48. Name, Address, City, State, 2	ip Code	Pich					nultiple visits)				,	P. TO				
and so young, state, 2	,															
					-	Χ_	Signed (Trea	ating Den	tist)				Date			
X(0) (0°2,00)						54. N	1.070	any Dell			55 Li	cense Numb				
						56 Address City State 7in Code 56a, Provider										
40. NIDI	PI 50. License Number 51. SSN or TIN						Guress, City,	JIGIE, ZI	, oode		Speci	alty Code				
49. NPI	SU. LICE	ense Numbe	51. SSN	N OF THIS												
x			Detail States		A Toronto											
52. Phone			52a. Additional	SERVICE SERVICE		57 P	hone (58 Ac	dditional				