

ATTENDING DENTIST'S STATEMENT

 Prior Authorization

 Claim

CARRIER	SUBMIT ALL CLAIM FORMS TO: Health Net Dental, Inc. Attn: Dental Claims P.O. Box 57074 Irvine, CA 92619-7074					
	PATIENT SECTION	1. Patient Name	2. Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other	3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	4. Patient's Birthdate Month Day Year	5. FOR OFFICE USE ONLY Effective Date ____/____/____ Paid Thru Date ____/____/____ Plan _____ Rate _____ Group/Subscriber No. _____
		6. Employee's Name and Mailing Address	7. Employee's Social Security No. or ID Number		8. Subscriber's Birthdate Month Day Year	
		9. Employer Name	10A. Group No.	10B. Identification No.		
		11A. Is patient covered by another plan of benefits? Dental _____ Medical _____	11B. Name and Address of Carrier(s)	11C. Group No.		

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. X _____ Signature (Patient or Parent if minor) _____ Date _____	I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me. X _____ Signature (Patient or Parent if minor) _____ Date _____
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DENTIST SECTION	12. Name of Billing Dentist or Dental Entity			20. Is treatment a result of occupational illness or injury? <input type="checkbox"/> No <input type="checkbox"/> Yes, if yes, brief description		
	13. Address Where Payment should be Remitted			21. Is treatment a result of auto accident? <input type="checkbox"/> No <input type="checkbox"/> Yes, if yes, brief description		
	City, State, Zip			22. Other Accident? 23. Are any services covered by another plan? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, brief description)		
	14. Soc. Security No. or T.I.N.	15. Dentist License No.	16. Dentist Phone No.	24. If Prosthesis, is this initial placement <input type="checkbox"/> No <input type="checkbox"/> Yes, if no, reason for replacement		25. Date of prior placement
	17. First Visit Date/Current Services	18. Place of Treatment Office/Hosp/Other	19. Radiographs or Models Enclosed <input type="checkbox"/> No <input type="checkbox"/> Yes, if yes, how many?	26. Is Treatment for Orthodontics? <input type="checkbox"/> No <input type="checkbox"/> Yes		Xrays returned on _____ By _____

Identify Missing Teeth with "X" * PLEASE SUBMIT X-RAYS AND POCKET DEPTH CHARTS WHEN APPROPRIATE.	27. Examination and Treatment Plan - List in order from tooth No. 1 through tooth No. 32 - Use charting system shown						For Administrative Use Only
	Tooth No. or Letter	Surface	Description of Service (including x-rays, prophylaxis, materials used, etc.)	Date of Service Performed Mo. Day Yr.	Procedure Number	Fee	

28. I hereby certify that the procedure as indicated by date have been completed and that the fees are the actual fees. I have charged and intended to collect for those procedures. Dentist's Signature _____ Date ____/____/____	Total Fee(s) Charged
	Carrier %
29. Address where treatment was performed, if different than box 13.	Carrier %
	Deductible
30. Remarks or comments for unusual services:	Carrier Pays