

DENTAL SERVICE REPORT

BLUE SHIELD USE ONLY

IMPORTANT: Treatment plans exceeding \$250.00 should be submitted for precertification. Failure to do so may result in patient responsibility for claims subsequently adjusted or denied.

SUBSCRIBER INFORMATION

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	INITIAL	LAST	7. EMPLOYEE/SUBSCRIBER SOCIAL SECURITY NO.			
8. MAILING ADDRESS STREET CITY STATE ZIP CODE				9-12. EMPLOYEE/SUBSCRIBER GROUP NO. AND/OR GROUP NAME			
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	POLICY NO.	NAME AND ADDRESS OF CARRIER			
<p>PATIENTS AUTHORIZATION: I hereby accept the above treatment plan and authorize the release of information relative to this course of treatment. I understand that I am responsible for the charges for any service not approved by benefit precertification review, for services which are not benefits of my dental plan or are rendered during any ineligible period and for the co-payments, deductibles and amounts exceeding the calendar year maximum of my dental plan. I understand that I may request a copy of the precertification review determination from Blue Shield of California.</p>						SIGNED (PATIENT OR PARENT IF MINOR)	DATE

DENTIST INFORMATION

18. DENTIST SOC. SEC. OR T.I.N.		19. DENTIST LICENSE NO.		20. DENTIST PHONE NO.		27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?		YES	NO		
21. FIRST VISIT DATE CURRENT SERIES	22. PLACE OF TREATMENT OFFICE HOSP. ECF OTHER		23. RADIOGRAPHS OR MODELS ENCLOSED?		YES	NO	HOW MANY?	28. IF PROSTHESIS/CROWN IS THIS INITIAL PLACEMENT?		IF NO, THE REASON FOR REPLACEMENT	29. DATE OF PRIOR PLACEMENT
24. IS TREATMENT RESULT OF OCCUPATION ILLNESS OR INJURY?		YES	NO	IF YES, ENTER BRIEF DESCRIPTION AND DATES			30. IS TREATMENT FOR ORTHODONTICS?		IF SERVICES ALREADY COMMENCED. ENTER	DATE APPLIANCES PLACED	MONTHS TREATMENT REMAINING
25. IS TREATMENT RESULT OF AUTO ACCIDENT?		I HEREBY CERTIFY THAT THE SERVICES LISTED HAVE BEEN OR WILL BE PROVIDED BY ME. →					DENTIST'S SIGNATURE		DATE		
26. OTHER ACCIDENT?											

31. EXAMINATION AND TREATMENT PLAN LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32

IDENTIFY MISSING TEETH WITH "X"	TOOTH NO OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED ETC.)	DATE SERVICE PERFORMED			ADA PROCEDURE NUMBER	FEE	BLUE SHIELD USE ONLY ALLOWED AMOUNT
				MO.	DAY	YEAR			
TOTAL FEE ACTUALLY CHARGED									

REMARKS:

32. DENTIST'S NAME, ADDRESS,
ZIP CODE & PROVIDER NUMBER