ATTENDING DENTIST'S STATEMENT

IMPORTANT: Please use separate copies of this form for ACTUAL SERVICES and PRE-DETERMINATION purposes. ACTUAL SERVICES PRE-DETERMINATION										P.O. Box 10909 Springfield, MO 65808												
	_	Patient name	2. Relationship to employee ☐ self ☐ child					3. 5 m	Sex f	4. Pati MM		oirthda OD		YYY	5.	If full time		city				
P	6.	6. Employee/subscriber name					☐ spouse ☐ other				8. Employee/subscri			per	<u></u>	9	Employ	yer (Cc	ompany	·)	10. (Group number
I	and mailing address					soc. sec. number			birthdate						, .	, , , , , , , , , , , , , , , , , , , ,						
ATIENT							мм	IM DD			YYYY .											
S	11.	Is patient covered by another plan of benefits? 12-a. Name and address of carrier(s)	L		12-b. (Grou	p no.(s)	13. Name and address of employer						
SECT		Dental Medical									14-c. Employee/subso											
ON	14					I ployee/subscriber c. sec. number			riber						15. Rela	lelationship to patient						
	(if different than patient's) soc.					ood. Namber			MM DD		YYYY			- 1	self parent spouse other							
	have reviewed the following treatment plan. I authorize release of any information relating											I hereby authorize payment directly to the below named								ntist of the	group in	surance
10	to this claim. I understand that I am responsible for all costs of dental treatment.									benefits otherwise payable to me.												
•	Signed (Patient, or parent if minor) Date										Signed (Insured person)								Date			
D	16. Dentist name										24. Is t	t No Yes			If yes, enter brief description and dates.							
DENTIST	17.	. Mailing address					illness or injury? 25. Is treatment resul			lt .	_	$\vdash \vdash$	<u> </u>									
İ											of a 26. Oth		cident? ident?)	_							
1		City, State, Zip					cov	Are any services covered by another plan?														
SECT	O 21. First visit date 22. Place of treatment 23. Re						20. Dentist phone no.				28. If prosthesis, is t initial placement										29. Date of prior placement	
N O I							adiographs or nodels enclosed?									If services already Date appliances Mos. treatment commenced placed remaining enter:						
	dent	Jentify missing teeth with "X" 31. Examination and treatment plan - List in order from tooth no. 1 th										oth no.	se char	ing s	Щ.						For	
	_		Tooth # or letter	Surface			service ys, prophylaxis, materials used, etc.)						Date ser perforn Mo. Day		ed	Proced numb			F	Fee	administrative use only	
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l h	ereb	y certify that the procedures actual fees I have charged a	as indi	cated by dend to colle	ate have ect for th	been co	ompleted and the edures.	t the fee	es s	submitted	1							Total Fee				
•											ate						_	Charged Max. Allowable				
Siç	ned	(Dentist)																Max. Allowable Deductible				
												Carrier %										
															Carrier pays							
																		Pati			T	

PLEASE READ BEFORE FILING YOUR DENTAL INSURANCE CLAIM

FOR THE EMPLOYEE

If the claim is on yourself complete items 1 through 11. If the claim is on your dependent also complete items 12 through 14. Sign and date the form where indicated - item 15. If you wish to have your benefits paid directly to the dentist complete item 16. INCOMPLETE CLAIM FORMS WILL HAVE TO BE RETURNED TO YOU FOR PROPER COMPLE-TION. THIS WILL DELAY CONSIDERATION AND PAYMENT OF YOUR CLAIM.

FOR THE DENTIST

Please complete Part II entitled "To be completed by the Attending Dentist." Wherever possible use the ADA procedure numbers listed below to describe the treatment rendered and indicate your fee for each service performed.

This list of dental procedures (adapted from the American Dental Association Uniform Code on Dental Procedures and Nomenclature) is provided for reference in completing the claim form. All procedures listed are not covered by every plan. The Group insurance contract determines services and benefits covered by any particular plan. Procedures not

listed below should be reported in terms of the ADA uniform code or by a narrative description. Dentists - please note: the lead zero (0) in the following ADA uniform codes has been omitted.

I. Diagnostic/General

Radiographs

- 0210 Intraoral complete series (with or without bitewings)
- 0220 Intraoral single, first film
- 0230 Intraoral each additional film
- 0240 Occlusal Single Film

0270 Bitwing

- 0330 Panoramic maxillary and maridibular single film
- 0340 Cephalometric radiograph

Tests and Laboratory Examinations

- 0430 Biopsy and examination of oral tissue, hard
- 0440 Biopsy and examination of oral tissue, soft
- 0460 Pulp vitality tests
- 0470 Diagnostic cast

II. Preventive

Dental Prophylaxis

- 1110 Adults
- 1120 Children under 12

Space Maintainers

- 1510 Fixed, band type
- 1515 Fixed, stainless steel crown type
- 1520 Fixed, cast type
- 1530 Removable, acrylic (with or without clasps or wires)

III. Restorative

Amalgam Restorations (deciduous teeth)

- 2110 Amalgam one surface
- 2120 Amalgam two surfaces
- 2130 Amalgam three surfaces

Amalgam Restorations (permanent teeth)

- 2140 Amaigam one surface
- 2150 Amalgam two surfaces
- 2160 Amalgam three surfaces
- 2170 Pin retained amalgam (in addition to above - per tooth)

Silicate Restorations

2210 Sificate cement - per restoration

Acrylic or Plastic Restorations

- 2310 Acrylic or Plastic
- 2320 Acrylic or Plastic (involving incisal angle)
- 2311 Pin retained (in addition to above per tooth)

Gold Foil Restorations

- 2410 Gold Foil one surface
- 2420 Gold Foil two surfaces 2430 Gold Foil - three surfaces

- Gold Inlay Restorations 2520 Inlay, gold - two surfaces
- 2530 Inlay gold three surfaces
- 2540 Onfay, (in addition to above per tooth)

Crowns - Single Restorations Only

2720 Plastic with metal

- 2740 Porcelain
- 2750 Porcelain with metal
- 2790 Gold (full cast)
- 2810 Gold (% cast)
- 2830 Stainless steel
- 2890 Dowel pin
- to above 2891 Post and core per tooth

in addition

Other Restorative Services

- 2910 Recement inlays
- 2920. Recement crowns

IV. Endodontics

Pulp Capping (excluding restoration)

- 3110 Pulp cap direct
- 3120 Pulp cap indirect

Pulpotomy (excluding restoration)

- 3210 Therapeutic apical closure
- 3220 Vital pulpotomy

Root Canal Therapy (includes treatment plan, clinical procedures, and follow-up care; excludes restoration)

- 3310 One canal
- 3311 One canal (in conjunction with apicoectomy)
- 3320 Two canals
- 3321 Two canals (in conjunction with apicoectomy)
- 3330 Three canals
- 3331 Three canals (in conjunction with apicoectomy)

Periapical Services

- 3410 Apicoectomy
- 3430 Retrograde filling
- 3920 Hemisection

V. Periodontics

Surgical Services

- 4210 Gingivectomy or gingivoplasty, per quadrant
- 4220 Gingival curettage, per quadrant
- 4260 Osseous surgery, per quadrant
- 4261 Osseous graft single site
- 4262 Osseous graft multiple site per quadrant

Adjunctive Services

- 4330 Occlusal adjustment (limited; not involving restoration)
- 4331 Occlusal adjustment (complete; not involving restoration)
- 4340 Periodontal scaling and root planing (12 or more teeth)
- 4341 Periodontal scaling and root planing (fewer than 12 teeth)

VI. Prosthodontics - Removable

Complete Dentures

- 5110 Complete upper
- 5120 Complete lower
- 5130 Immediate upper 5140 Immediate lower

Partial Dentures

- 5230 Lower with gold or chrome lingual bar and two clasps, acrylic base
- 5240 Lower with gold or chrome lingual bar and two clasps, cast base
- 5250 Upper with gold or chrome palatal
- bar and two clasps, acrylic base 5260 Upper with gold or chrome palatal bar and two clasps, cast base
- 5310 Each additional clasp

Adjustments to denture (6 mos. after installation or by dentist other than dentist providing appliances)

- 5410 Complete denture
- 5420 Partial denture

Repairs to Dentures

- 5610 Repair broken complete or partial denture, no teeth damaged
- 5620 Repair broken complete or partial denture and replace one broken tooth
- 5630 Replace additional teeth, each
- tooth 5640 Replace broken tooth on denture,

no other repairs Adding teeth to partial to replace extracted tooth:

- 5650 Each tooth not involving clasp
- 5660 Each tooth involving clasp
- 5670 Reattaching damaged clasp on
- 5680 Replacing broken clasp with new clasp on denture
- 5690 Each additional broken clasp with rest
- 5750 Relining upper or lower complete denture (laboratory)
- Relining upper or lower partial denture (laboratory)
- 5850 Tissue conditioning

VII. Prosthodontics - Fixed

Fixed Bridges

Bridge Pontics

- 6210 Cast gold
- 6220 Slotted (Steele's) facing
- 6230 Slotted (Tru) Pontic
- 6240 Porcelain fused to metal

6250 Plastic processed to metal **Abutments**

- 6520 Two surface gold inlay
- 6530 Three or more surface gold inlay 6540 Gold onlay (in addition to above per tooth)

Repairs

- 6610 Replace broken pin facing with slotted (Steele's) or other facing
- 6620 Replace broken facing where post is intact
- 6630 Replace broken facing where post backing is broken

- 6640 Replace broken facing with acrylic 6650 Replace broken slotted Tru Pontic Crowns
- 6720 Plastic processed to metal
- 6750 Porcelain fused to metal
- 6780 Gold (3/4 cast)
- 6790 Gold (full cast)
- Other Services
- 6930 Recement bridge 6960 Dowel pin - in addition to above per tooth

VIII. Oral Surgery

(All procedures include local anesthesia and postoperative care)

Simple extractions

- 7110 Single tooth
- 7120 Each additional tooth

Surgical Extractions

- 7220 Extraction of tooth, soft tissue impaction
- 7230 Extraction of tooth, partial bony impaction
- 7240 Extraction of tooth, complete bony

impaction Alveoplasty (surgical preparation of

- ridge for dentures) 7310 Per sextant, in conjunction with extractions
- 7320 Per sextant, not in conjunction with extractions
- 7438 Excisions or removal of tumor. cyst or neoplasms

7470 Removal of exostosis Comprehensive Full Banded Treatment

- 8010 Preliminary Study (including cephalometric radiographs. diagnostic casts and treatment
- nlan) 8020 First month of active treatment including all active and retention appliances
- 8030 Active treatment, per month after first month
- 8040 Retention treatment per visit 8050 Examination, treatment, or adjust-

ment, per visit Other Orthodontic Treatment Appliances for Tooth Guidance (not

- more than one per case) 8110 Removable
- 8120 Fixed or cemented

Appliances to control harmful habits (not more than one per case)

Orthodontic retention appliances (not

- 8210 Removable 8220 Fixed or cemented
- more than one per case) 8310 Removable
- 8320 Fixed or cemented