

HEADER INFORMATION																			
1. Type of Transaction (Mark all applicable boxes) <input checked="" type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT/Title XIX																			
A. Predetermination/Preauthorization Number																			
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION																			
3. Company/Plan Name, Address, City, State, Zip Code Hewlett Packard Enterprise – RI Medicaid P.O. Box 2010 Warwick, RI 02887-2010																			
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)																			
4. Dental? <input checked="" type="checkbox"/> Medical? <input type="checkbox"/> (If both, complete 5-11 for dental only.)																			
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix) Jones, Mary R																			
6. Date of Birth (MM/DD/CCYY) 02/02/1976	7. Gender <input type="checkbox"/> M <input checked="" type="checkbox"/> F	8. Policyholder/Subscriber ID (SSN or ID#) ABC123456																	
9. Plan/Group Number DEF789123	10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Dependent <input type="checkbox"/> Other																		
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code 22T - American Dental																			
RECORD OF SERVICES PROVIDED																			
24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee										
06/20/2014					D0140		1	Limited Oral Evaluation	100.00										
06/20/2014					D1110		1	Prophylaxis-Adult	80.00										
06/20/2014			14	B,O	D2392		1	Resin-based, two surfaces, posterior	150.00										
06/20/2014			19	L,O	D2393		1	Resin-based, three surfaces, posterior	150.00										
								Primary Insurance Payment	-200.00										
33. Missing Teeth Information (Place an "X" on each missing tooth.)					34. Diagnosis Code List Qualifier (ICD-9 = B; ICD-10 = AB)			31a. Other Fee(s)											
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	34a. Diagnosis Code(s) A _____ C _____		32. Total Fee	
																(Primary diagnosis in "A") B _____ D _____		480.00	
35. Remarks																			

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)		
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code Smith, Jane L 123 Main Street Any Town, RI 02000		
13. Date of Birth (MM/DD/CCYY) 01/01/1999	14. Gender <input type="checkbox"/> M <input checked="" type="checkbox"/> F	15. Policyholder/Subscriber ID (SSN or ID#) 1000055555
16. Plan/Group Number	17. Employer Name	
PATIENT INFORMATION		
18. Relationship to Policyholder/Subscriber in #12 Above <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other		19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code Smith, Jane L 123 Main Street Any Town, RI 02000		
21. Date of Birth (MM/DD/CCYY) 01/01/1999	22. Gender <input type="checkbox"/> M <input checked="" type="checkbox"/> F	23. Patient ID/Account # (Assigned by Dentist) JS1234

AUTHORIZATIONS	
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all 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 or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.	
X _____ Signature on file Patient/Guardian Signature	0000000000 02/20/2014 Date
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.	
X _____ Signature on file Subscriber Signature	0000000000 02/20/2014 Date

ANCILLARY CLAIM/TREATMENT INFORMATION	
38. Place of Treatment _____ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")	
39. Enclosures (Y or N) <input checked="" type="checkbox"/> N	
40. Is Treatment for Orthodontics? <input checked="" type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)	
41. Date Appliance Placed (MM/DD/CCYY)	
42. Months of Treatment Remaining	
43. Replacement of Prosthesis <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (Complete)	
44. Date of Prior Placement (MM/DD/CCYY)	
45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident	
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 submitting claim on behalf of the patient or insured/subscriber.)		
48. Name, Address, City, State, Zip Code Happy Smiles Dental Associates 500 Your Street, Suite 301 Providence, RI 02905		
49. NPI 1112223334	50. License Number 1223G0001X	51. SSN or TIN 05-5555555
52. Phone Number (401) 555 - 5555		52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION		
53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.		
X <u>John Jones, DDS</u> Signed (Treating Dentist)		06/20/2014 Date
54. NPI 1234567890	55. License Number	DENXXXXX
56. Address, City, State, Zip Code 500 Your Street, Suite. 301 Providence, RI 02905		56a. Provider Specialty Code 122300000X
57. Phone Number (401) 555 - 5555		58. Additional Provider ID