Attending Dentist's Statement

Check one:

☐ Dentist's Pre-treatment Estimate

☐ Dentist's Statement of Actual Services

UnitedHealthcare Dental
Claims Division
P.O. Box 30560
Bethesda, MD 20824-0560

PATIENT SECTION

1. PATIENT NAME (FIRST / MIDDLE / LAST)	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 NAME (FIRST / MIDDLE / LAST)	7. EMPLOYEE SOCIAL SECURITY NO.	9. NAME OF GROUP DENTAL PROGRAM

8. EMPLOYEE MAILING ADDRESS	10. EMPLOYER (COMPANY) NAME AND ADDRESS
CITY, STATE, ZIP	

11. GROUP NUMBER	12. LOCATION	13. ARE OTHER FAMILY MEMBERS EMPLOYED? ☐ YES ☐ NO (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	GROUP NUMBER	NAME AND ADDRESS OF CARRIER

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

SIGNED (PATIENT OR PARENT, IF MINOR) DATE

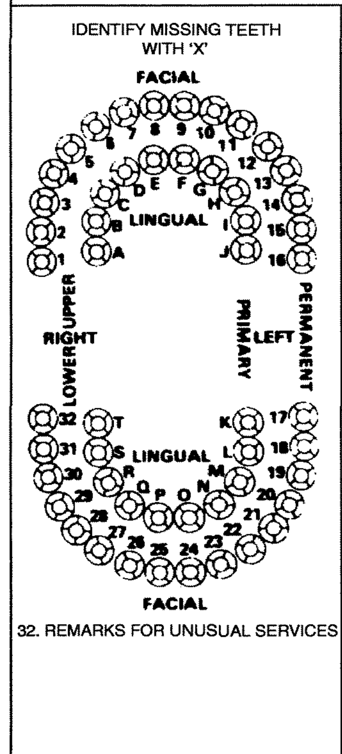
I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT. I WISH TO ASSIGN BENEFITS TO THE BELOW NAMED DENTIST. ☐ YES ☐ NO

SIGNED (INSURED PERSON) DATE

DENTIST SECTION

16. DENTIST NAME		NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
17. NAME OF REFERRING DENTIST	24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
18. MAILING ADDRESS	25. IS TREATMENT RESULT OF AUTO ACCIDENT?			
CITY, STATE, ZIP	26. OTHER ACCIDENT?			
19. DENTIST SOC. SEC. OR T.I.N. / 20. DENTIST LICENSE NO. / 21. DENTIST PHONE NO.	27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
22. FIRST VISIT DATE CURRENT SERIES / 23. PLACE OF TREATMENT (OFFICE / HOSP / ECF / OTHER) / 24. RADIOGRAPHS OR MODELS ENCLOSED (NO / YES / HOW MANY?)	28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			IF NO, REASON FOR REPLACEMENT / 29. DATE OF PRIOR PLACEMENT

IDENTIFY MISSING TEETH WITH 'X'



32. REMARKS FOR UNUSUAL SERVICES

31. Examination and Treatment Plan – List in Order From Tooth No. 1 Through Tooth No. 32
Use Charting System Shown.

Tooth # or Letter	Surface	Description of Service (Including X-Rays, Prophylaxis, Materials Used, Etc.) LINE NO.	Date Service Performed Mo.	Day	Yr.	Procedure Number	Fee	For Administrative Use Only
		1						
		2						
		3						
		4						
		5						
		6						
		7						
		8						
		9						
		10						
		11						
		12						
		13						
		14						
		15						

I Hereby Certify That The Services Listed Above Will Be ☐ Have Been ☐ Performed

Signed (Dentist) Date

TOTAL FEE CHARGED	
MAX. ALLOWABLE	
DEDUCTIBLE	
CARRIER %	
CARRIER PAYS	
PATIENT PAYS	

Form Approved by the Council on Dental Care Programs of the A.D.A. 1997

100-2414 8/99

INSTRUCTIONS TO THE DENTIST:

1) Any claim that is being submitted for reimbursement (procedure codes 2700 and above) must be accompanied by pre-operative X-rays. Endodontic procedures require pre-and post-operative X-rays, while periodontal claims require charting and X-rays of affected teeth. Please do not send originals. These will be reviewed and returned to your office.
2) Submit all claims to UnitedHealthcare Dental at:

Claims Division
P.O. Box 30560
Bethesda, MD 20824-0560
(800) 445-9090