Dental Claim Form

☐ Dentist's pre-treatment estimate Specialty (see backside)
☐ Dentist's statement of actual services
☐ Medicaid Claim Prior Authorization #
☐ EPSDT

Manhasset Education Association
Mail claims to:
Daniel H Cook Associates
253 West 35th Street, 12th Fl
New York, NY 10001-1907

PATIENT

Patient Name (Last, First, Middle)	Address	City	State

Date of Birth (MM/DD/YYYY)	Patient ID #	Sex	Phone Number	Zip Code
/ /		☐M ☐F	( )	

Relationship to Subscriber/Employee:
☐Self ☐Spouse ☐Child ☐Other_____

Employer/School
Name_____ Address_____

SUBSCRIBER / EMPLOYEE

Subs./Emp. ID#/SSN#	Employer Name	Group #

Subscriber/Employee Name (Last, First, Middle)

Address	Phone Number	City	State	Zip Code
	( )			

Date of Birth (MM/DD/YYYY)	Marital Status	Sex
/ /	☐Married ☐Single ☐Other	☐M ☐F

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 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 under applicable law, I authorize release of any information relating to this claim.

X_____
Signed (Patient/Guardian) Date (MM/DD/YYYY)

OTHER POLICIES

Is Patient covered by another plan	Policy #
☐No ☐Yes: ☐Dental or ☐ Medical	

Other Subscriber's Name

Date of Birth (MM/DD/YYYY)	Sex	Plan/Program Name
/ /	☐M ☐F	

Employer/School
Name_____ Address_____

Subscriber/Employee Status
☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student

Employer/School
Name_____ Address_____

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

X_____
Signed (Employee/subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

Name of Billing Dentist or Dental Entity	Phone Number	Provider ID #	Dentist Soc. Sec. or T.I.N.
	( )		

Address	Dentist License #	First visit date of current series:	Place of treatment
			☐Office ☐Hosp. ☐ECF ☐Other

City	State	Zip Code	Radiographs or models enclosed?	Is treatment for orthodontics? ☐Yes ☐No
			☐Yes, How many?_____ ☐No	If service already commenced:

If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No
If no, reason for replacement: _____
Date of prior placement: _____
Date appliances placed _____
Total mos. of treatment remaining _____

Is treatment result of occupational illness or injury? ☐No ☐ Yes
Brief description and dates_____

Is treatment result of: ☐auto accident? ☐other accident? ☐neither
Brief description and dates_____

Diagnosis Code Index (optional)
1._____ 2._____ 3._____ 4._____ 5._____ 6._____ 7._____ 8._____

Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee

Admin. Use Only

Identify all missing teeth with "X"

Permanent									Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

Remarks for unusual services

Total Fee	
Payment by other plan	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X_____
Signed (Treating Dentist) License # Date (MM/DD/YYYY)

Address where treatment was performed

City	State	Zip Code