DENTAL CLAIM FORM

1. ☐ Dentist's pre-treatment estimate
☐ Dentist's statement of actual services
Provider ID No.

2. ☐ Medicaid Claim
☐ EPSDT
Prior Authorization No.
Patient ID No.

3. Carrier name and Address

PATIENT COVERAGE

4. Patient name — first / m.i. / last

5. Relation to insured — ☐ self ☐ child ☐ spouse ☐ other

6. Sex — m f

7. Patient birthdate — MM DD YYYY

8. If full time student — school city

9. Employee/subscriber name and mailing address

10. Employee/subscriber soc sec number

11. Employee/subscriber birthdate — MM DD YYYY

12. Employer (company) name and address

13. Group number

14. Is patient covered by another dental plan? If yes, complete 15-a. ☐ Yes ☐ No
Is patient covered by a medical plan? ☐ Yes ☐ No

15-A. Name and address of carrier(s)

15-B. Group No.(s)

16. Name and address of employer

17-A. Employee/subscriber name (if different than patient's)

17-B. Employee/subscriber soc. sec. number

17-C. Employee/subscriber birthdate — MM DD YYYY

18. Relationship to insured — ☐ self ☐ child ☐ spouse ☐ other

19. I have reviewed the following treatment plan and 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.

Signed (Patient, or parent if minor)

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

Signed (Employee/subscriber)

BILLING DENTIST

21. Name of Billing Dentist or Dental Entity
Robert C. Graber, D.M.D.

22. Address of where payment should be remitted
135 Union Avenue

23. City, State, Zip
Rutherford, NJ 07070

24. Dentist Soc Sec or T.I.N.
TIN:223034622

25. Dentist license No.
012733

26. Dentist phone No.
(201) 438-2373

30. Is treatment result of occupational illness or injury? No ☐ Yes ☐ If yes, enter brief description and dates

31. Auto accident? No ☐ Yes ☐

32. Other accident? No ☐ Yes ☐

33. If prosthesis, is this initial placement? ☐ ☐ (If no, reason for replacement)

34. Date of prior placement

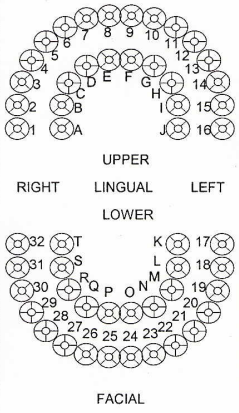
27. First visit date current series

28. Place of treatment Office Hosp ECF Other

29. Radiographs No ☐ Yes ☐ How Many?

35. Is treatment for orthodontics? ☐ ☐ If services already commenced, enter: Date appliances placed Mos. treatment remaining

36. Identify missing teeth with "x"



37. Examination and treatment plan-List in order from tooth No. 1 through tooth No. 32 - Use charting system shown.

Tooth No. or letter	Surface	Description of service (including x-rays, prophylaxis, materials, etc.) Line No.	Date service performed MM DD YY	Procedure Number	Fee

For administrative use only

38. Remarks for unusual services

39. I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

012733

Robert C. Graber, D.M.D.
(Treating Dentist)

License Number

Date

40. Address where treatment was performed
135 Union Avenue Rutherford NJ 07070
City State Zip

41. Total Fee Charged	
42. Payment by other plan	
Max allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

1994 Revision PAT ID: 118001 PRIMARY CLAIM No.: 19598