American Dental Association Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☒ Statement of Actual Service ☐ Request for Predetermination/Preauthorization

☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

CIGNA
P.O. Box 188040
Chattanooga, TN 37422

OTHER COVERAGE

4. Other Dental or Medical Coverage ☐ No (Skip 5-11) ☒ Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number	10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

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POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

Bluemling, Mark
141 Meadow Ridge Lane
Guilford, CT 06437

13. Date of Birth(MM/DD/CCYY)	14. Gender ☒ M ☐ F	15. Policyholder/Subscriber ID (SSN or ID#)
01/09/1947		U10680385

16. Plan/Group Number	17. Employer Name
2466066	AT&T (retired)

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☒ Self ☐ Spouse ☐ Dependent Child ☐ Other	19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

Bluemling, Mark
141 Meadow Ridge Lane
Guilford, CT 06437

21. Date of Birth(MM/DD/CCYY)	22. Gender ☒ M ☐ F	23. Patient ID/Account # (Assigned by Dentist)
01/09/1947		1005639

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	30. Description	31. Fee
1	10/21/2009					D0120		52.00
2	10/21/2009					D1110		143.00
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent															
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Primary									
A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)

33. Total Fee 195.00

35. Remarks

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 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

Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☒ Provider's Office ☐ Hospital ☐ ECF ☐ Other	39. Number of Enclosures (00 to 99) Radiograph(s): 0 Oral Image(s): 0 Model(s): 0
40. Is Treatment for Orthodontics? ☒ No (Skip 41 - 42) ☐ Yes (Complete 41 - 42)	41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining	43. Replacement of Prosthesis? ☒ No ☐ Yes (Complete 44) / 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from

☐ Occupational illness/injury ☐ Auto accident ☐ 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

Dean G Cloutier D.D.S.
New Haven Dental Group
195 Monotowese Street
Branford, CT 06405

49. NPI	50. License Number	51. SSN or TIN
1609916089	5202	061025204

52. Phone Number (203) 488-0091	52A. Additional Provider ID 10002

TREATING DENTIST AND TREATING 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

Signed (Treating Dentist) Date

54. NPI 1558382432	55. License Number 5202
56. Address, City, State, Zip Code	56A. Provider Specialty Code

57. Phone Number	58. Additional Provider ID 10002