ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

[X] Statement of Actual Services [ ] Request for Predetermination/Preauthorization

[X] EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

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

METLIFE
PO BOX 981282
EL PASO, TX 79998

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)

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

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

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

GRANILLO, ERIC J
529 INVERNESS DR
WINSTON SALEM, NC 27107

13. Date of Birth (MM/DD/CCYY): 07/20/1972

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): 550337639

16. Plan/Group Number: 120731

17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above: [ ] Self [ ] Spouse [X] Dependent Child [ ] Other

19. Reserved For Future Use

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

GRANILLO, JACKSON
529 INVERNESS DR
WINSTON SALEM, NC 27107

21. Date of Birth (MM/DD/CCYY): 07/26/2002

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 805131162905

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
1	12/10/2016					D8670			PERIOD ORTHO TX INSTALLMENT	141.00
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

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

34. Diagnosis Code List Qualifier [ ] [ ] (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____

31a. Other Fee(s)

32. Total Fee: 141.00

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: 2016/12/10

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 — Date: 2016/12/10

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment: 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N): [ ]

40. Is Treatment for Orthodontics? [ ] No (Skip 41-42) [X] Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY): 8/5/2016

42. Months of Treatment: 20

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

Kenneth M. Sadler, DDS and Associates, PA
201 Charlois Boulevard
Winston-Salem, NC 27103

49. NPI: 1144309410

50. License Number: 4151

51. SSN or TIN: 56-2132966

52. Phone Number: (336) 331-3500

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 Dr Deborah F Novak — Signed (Treating Dentist) — Date: 2016/12/10

54. NPI: 1457441420

55. License Number

56. Address, City, State, Zip Code: 201 Charlois Blvd, Winston-Salem, NC 27103

56a. Provider Specialty Code: 1223X0400X

57. Phone Number: (336) 331-3500

58. Additional Provider ID