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

ACS Benefit Service, Inc.
P O Box 2050
Winston-Salem, NC 27102-2050

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

DEBERRY, ELISABETH HOOVER
353 JONESTOWN RD STE 217
WINSTON SALEM, NC 27104

13. Date of Birth (MM/DD/CCYY): 06/22/1973

14. Gender: [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#): 0002600009

16. Plan/Group Number: 003

17. Employer Name: WAKE FOREST UNIVERSITY

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

DEBERRY, NIKOLOS
353 JONESTOWN RD STE 217
WINSTON SALEM, NC 27104

21. Date of Birth (MM/DD/CCYY): 12/12/2003

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 805036162904

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	199.58
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: 199.58

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 7/29/2015

42. Months of Treatment: 7

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) — 11/28/2016 — Date

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

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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

ACS Benefit Service, Inc.
P O Box 2050
Winston-Salem, NC 27102-2050

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	8. Policyholder/Subscriber ID (SSN or ID#)
	[ ] M [ ] F	

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

DOSS, DAVID
2812 LORI LANE
YADKINVILLE, NC 27055

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Policyholder/Subscriber ID (SSN or ID#)
04/29/1977	[X] M [ ] F	L010001770

16. Plan/Group Number	17. Employer Name
003	WAKE FOREST UNIVERSITY

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above	19. Reserved For Future Use
[ ] Self [ ] Spouse [X] Dependent Child [ ] Other	

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

DOSS, OLIVER
P O BOX 1
RURAL HALL, NC 27045

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
09/14/2002	[X] M [ ] F	805066162903

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	11/5/2015					D8080			Comprehensive Adolescent Treatment	4,950.00
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 4,950.00

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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) 11/5/2015

42. Months of Treatment 24

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	50. License Number	51. SSN or TIN
1144309410	4151	56-2132966

52. Phone Number	52a. Additional Provider ID
(336) 331-3500	

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) — 11/28/2016 — Date

54. NPI	55. License Number
1457441420	

56. Address, City, State, Zip Code	56a. Provider Specialty Code
201 Charlois Blvd Winston-Salem, NC 27103	1223X0400X

57. Phone Number	58. Additional Provider ID
(336) 331-3500	

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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

ACS Benefit Service, Inc.
P O Box 2050
Winston-Salem, NC 27102-2050

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

ABHULIMEN, MICHAEL E
3476 SALLY KIRK ROAD
WINSTON SALEM, NC 27106

13. Date of Birth (MM/DD/CCYY): 09/17/1970

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): L010001560

16. Plan/Group Number: 003

17. Employer Name: WFBMC

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

ABHULIMEN, ONO
3476 SALLY KIRK ROAD
WINSTON SALEM, NC 27106

21. Date of Birth (MM/DD/CCYY): 12/12/2001

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805097162902

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	228.10
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: 228.10

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 3/10/2016

42. Months of Treatment: 12

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) — 11/28/2016 — Date

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

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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

AMERITAS
P O BOX 82520
LINCOLN, NE 68501

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

HALL, JONATHAN B
100 SEDGEWICK RIDGE COURT
LEWISVILLE, NC 27023

13. Date of Birth (MM/DD/CCYY): 03/01/1974

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): 243136859

16. Plan/Group Number: 301224

17. Employer Name: FORSYTH COUNTY

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

HALL, MADISON C
100 SEDGEWICK RIDGE COURT
LEWISVILLE, NC 27023

21. Date of Birth (MM/DD/CCYY): 05/02/2002

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805105162901

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	100.00
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: 100.00

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 3/29/2016

42. Months of Treatment: 15

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) — 11/28/2016 — Date

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

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[X] EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

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

AMERITAS
P O BOX 82520
LINCOLN, NE 68501

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

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

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

CHARLES CHERRY

6. Date of Birth (MM/DD/CCYY)	7. Gender	8. Policyholder/Subscriber ID (SSN or ID#)
12/22/1956	[X] M [ ] F	D49006217

9. Plan/Group Number	10. Patient's Relationship to Person named in #5
0510540001	[ ] Self [X] Spouse [ ] Dependent [ ] Other

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

DELTAL DENTAL OF MI
PO BOX 9085
FARMINGTON HILLS, MI 48333

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

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

CHERRY, DR. JEWEL
652 BARROCLIFF ROAD
CLEMMONS, NC 27012

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Policyholder/Subscriber ID (SSN or ID#)
11/11/1959	[ ] M [X] F	250254867

16. Plan/Group Number	17. Employer Name
350488	FORSYTH TECH

PATIENT INFORMATION

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

19. Reserved For Future Use

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

CHERRY, DR. JEWEL
652 BARROCLIFF ROAD
CLEMMONS, NC 27012

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
11/11/1959	[ ] M [X] F	805115162900

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	148.60
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 148.60

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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) 4/26/2016

42. Months of Treatment 6

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	50. License Number	51. SSN or TIN
1144309410	4151	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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI 1790716421

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 903HC

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or go online at adacatalog.org

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

AMERITAS
P O BOX 82520
LINCOLN, NE 68501

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

CORNE, JODY WAYNE
1824 WEST WESTMORELAND RD
KING, NC 27021

13. Date of Birth (MM/DD/CCYY): 05/02/1977

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): 242696904

16. Plan/Group Number: 350473

17. Employer Name: KRISPY KREME DOUGHNUT CORP

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

CORNE, MARY CATHERINE
1824 WEST WESTMORELAND RD
KING, NC 27021

21. Date of Birth (MM/DD/CCYY): 01/05/2004

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805056162899

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	83.34
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: 83.34

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 9/21/2015

42. Months of Treatment: 9

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

AMERITAS
P O BOX 82520
LINCOLN, NE 68501

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

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

EAST, GARY L
112 MEADOW RD
DANBURY, NC 27016

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Policyholder/Subscriber ID (SSN or ID#)
07/24/1971	[X] M [ ] F	243273552

16. Plan/Group Number	17. Employer Name
301224	FORSYTH COUNTY GOVERNMENT

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

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

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

BECKY M EAST

6. Date of Birth (MM/DD/CCYY)	7. Gender	8. Policyholder/Subscriber ID (SSN or ID#)
07/14/1975	[ ] M [X] F	015957635

9. Plan/Group Number	10. Patient's Relationship to Person named in #5
5476379	[ ] Self [ ] Spouse [X] Dependent [ ] Other

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

Assurant
P O Box 2940
Clinton, IA 52733

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

EAST, ISAIAH
112 MEADOW RD
DANBURY, NC 27016

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
10/11/2000	[X] M [ ] F	805045162898

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	100.00
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 100.00

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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) 8/11/2015

42. Months of Treatment 11

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	50. License Number	51. SSN or TIN
1144309410	4151	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) — 11/28/2016 — Date

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

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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

AMERITAS
P O BOX 82520
LINCOLN, NE 68501

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

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

CRAVER, JILL
203 NIFONG RD
CLEMMONS, NC 27012

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Policyholder/Subscriber ID (SSN or ID#)
08/30/1974	[ ] M [X] F	246150990

16. Plan/Group Number	17. Employer Name
377272	DAVIDSON COUNTY B O E

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

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

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

KEITH WILKE

6. Date of Birth (MM/DD/CCYY)	7. Gender	8. Policyholder/Subscriber ID (SSN or ID#)
10/03/1973	[X] M [ ] F	101774646

9. Plan/Group Number	10. Patient's Relationship to Person named in #5
00183058	[ ] Self [ ] Spouse [X] Dependent [ ] Other

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

CIGNA
PO BOX 188037
CHATTANOOGA, TN 37422-8037

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above	19. Reserved For Future Use
[ ] Self [ ] Spouse [X] Dependent Child [ ] Other	

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

CRAVER, COLTON R
203 NIFONG RD
CLEMMONS, NC 27012

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
02/25/2003	[X] M [ ] F	800514162897

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	83.34
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 83.34

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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) 3/17/2015

42. Months of Treatment 3

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	50. License Number	51. SSN or TIN
1144309410	4151	56-2132966

52. Phone Number	52a. Additional Provider ID
(336) 331-3500	

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI	55. License Number
1790716421	

56. Address, City, State, Zip Code	56a. Provider Specialty Code
201 Charlois Blvd Winston-Salem, NC 27103	1223X0400X

57. Phone Number	58. Additional Provider ID
(336) 331-3500	903HC

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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

AMERITAS
P O BOX 82520
LINCOLN, NE 68501

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

BRANCH, GLADYS C
733 BRASSIE CLUB DR
ROCKY MOUNT, NC 27804

13. Date of Birth (MM/DD/CCYY): 07/21/1960

14. Gender: [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#): 245170145

16. Plan/Group Number: 350369

17. Employer Name: NASH-ROCKY MOUNT SCHOOLS

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

BRANCH, CAMILLE
733 BRASSIE CLUB DR
ROCKY MOUNT, NC 27804

21. Date of Birth (MM/DD/CCYY): 05/11/1995

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805120162896

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	111.12
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: 111.12

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 5/5/2016

42. Months of Treatment: 11

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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[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

AMERITAS
P O BOX 82520
LINCOLN, NE 68501

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

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

JACOBS, RYAN W
1612 CRATER LANE
YADKINVILLE, NC 27055

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Policyholder/Subscriber ID (SSN or ID#)
04/02/1980	[X] M [ ] F	237351748

16. Plan/Group Number	17. Employer Name
301323	YADKIN VALLEY TELEPHONE

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

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

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

RENEE JACOBS

6. Date of Birth (MM/DD/CCYY)	7. Gender	8. Policyholder/Subscriber ID (SSN or ID#)
09/25/1973	[ ] M [X] F	912204270

9. Plan/Group Number	10. Patient's Relationship to Person named in #5
460824	[ ] Self [ ] Spouse [X] Dependent [ ] Other

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

GUARDIAN
P O BOX 2459
SPOKANE, WA 99210

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

JACOBS, MAKAYLA
1612 CRATER LANE
YADKINVILLE, NC 27055

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
05/16/2003	[ ] M [X] F	800502162895

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	83.34
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 83.34

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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) 8/25/2016

42. Months of Treatment 21

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	50. License Number	51. SSN or TIN
1144309410	4151	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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI 1790716421

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 903HC

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or go online at adacatalog.org

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

Assurant
P O Box 2940
Clinton, IA 52733

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

LEVY, TERESA A
391 ACT DRIVE
WINSTON SALEM, NC 27107

13. Date of Birth (MM/DD/CCYY): 04/03/1971

14. Gender: [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#): 147788674

16. Plan/Group Number: 5473703

17. Employer Name: MODERN AUTOMOTIVE

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

LEVY, ERICA N
391 ACT DRIVE
WINSTON SALEM, NC 27107

21. Date of Birth (MM/DD/CCYY): 12/12/2005

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805101162894

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	71.44
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: 71.44

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: 11/28/2016

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: 11/28/2016

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): 4/20/2016

42. Months of Treatment: 16

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. Martin Slominski — Signed (Treating Dentist) — Date: 11/28/2016

54. NPI: 1790716421

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: 903HC

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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

BCBSNC, CLAIMS UNIT
PO BOX 2100
WINSTON-SALEM, NC 27102

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

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

POTTS, RYAN J
145 NORWOOD FOREST LANE
TOBACCOVILLE, NC 27050

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Policyholder/Subscriber ID (SSN or ID#)
11/06/1973	[X] M [ ] F	W13694289

16. Plan/Group Number	17. Employer Name
080960	RAI

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	8. Policyholder/Subscriber ID (SSN or ID#)
	[ ] M [ ] F	

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

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above	19. Reserved For Future Use
[ ] Self [ ] Spouse [X] Dependent Child [ ] Other	

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

POTTS, ANNIE C
145 NORWOOD FOREST LANE
WINSTON SALEM, NC 27106

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
04/28/2004	[ ] M [X] F	805071162893

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	206.25
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 206.25

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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) 1/5/2016

42. Months of Treatment 12

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	50. License Number	51. SSN or TIN
1144309410	4151	56-2132966

52. Phone Number	52a. Additional Provider ID
(336) 331-3500	

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) — 11/28/2016 — Date

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	58. Additional Provider ID
(336) 331-3500	

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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

BCBSNC, CLAIMS UNIT
PO BOX 2100
WINSTON-SALEM, NC 27102

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

SPEIGHTS, KENNETH
4840 BARKAS DR
WINSTON-SALEM, NC 27106

13. Date of Birth (MM/DD/CCYY): 11/25/1965

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): W13694110

16. Plan/Group Number: 080960

17. Employer Name: REYNOLDS

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

SPEIGHTS, KENADY
4840 BARKAS DR
WINSTON-SALEM, NC 27106

21. Date of Birth (MM/DD/CCYY): 06/30/2001

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 803332162892

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	206.25
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: 206.25

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 1/15/2015

42. Months of Treatment: 1

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

BCBSNC, CLAIMS UNIT
PO BOX 2100
WINSTON-SALEM, NC 27102

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

BURKEY, KEVIN
1324 ROBINHOOD FOREST DR
PFAFFTOWN, NC 27040

13. Date of Birth (MM/DD/CCYY): 04/01/1969

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): W13694414

16. Plan/Group Number: 080960

17. Employer Name: RAI

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

BURKEY, MILES D
1324 ROBINHOOD FOREST DR
PFAFFTOWN, NC 27040

21. Date of Birth (MM/DD/CCYY): 06/08/2001

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 805020162891

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	199.58
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: 199.58

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 5/7/2015

42. Months of Treatment: 6

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) — 11/28/2016 — Date

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

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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

Blue Cross Blue Shield
P O Box 75
Minneapolis, MN 55440-0075

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

STURTEVANT, ERIC
445 WARREN BRIDGE RD
UNION GROVE, NC 28689

13. Date of Birth (MM/DD/CCYY): 11/11/1967

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): F79360313

16. Plan/Group Number: FEPBD1-0002

17. Employer Name: FEDERAL GOVERNMENT

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

STURTEVANT, MORGAN
445 WARREN BRIDGE RD
UNION GROVE, NC 28689

21. Date of Birth (MM/DD/CCYY): 02/26/2003

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805113162890

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	105.42
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: 105.42

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: 11/28/2016

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: 11/28/2016

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): 5/18/2016

42. Months of Treatment: 29

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. Martin Slominski — Signed (Treating Dentist) — Date: 11/28/2016

54. NPI: 1790716421

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: 903HC

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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

BLUE CROSS BLUE SHIELD
P O BOX 659444
SAN ANTONIO, TX 78265

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

MARSH, HEATHER D
245 SHALLOW POND LN
MOUNT AIRY, NC 27030

13. Date of Birth (MM/DD/CCYY): 11/06/1977

14. Gender [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#): GUK918A76090

16. Plan/Group Number: GA7147M007

17. Employer Name: MT AIRY DIALYSIS

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

MARSH, CLOE D
245 SHALLOW POND LN
MOUNT AIRY, NC 27030

21. Date of Birth (MM/DD/CCYY): 12/14/2005

22. Gender [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805142162889

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	199.58
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: 199.58

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: 11/28/2016

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: 11/28/2016

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): 8/30/2016

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. Martin Slominski — Signed (Treating Dentist) — Date: 11/28/2016

54. NPI: 1790716421

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: 903HC

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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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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

PHAN, HUNG M
6622 RIDGE RUN COURT
CLEMMONS, NC 27012

13. Date of Birth (MM/DD/CCYY): 01/15/1961

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): W13695419

16. Plan/Group Number: 080960

17. Employer Name: RAI

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

PHAN, EMILY K
6622 RIDGE RUN COURT
CLEMMONS, NC 27012

21. Date of Birth (MM/DD/CCYY): 02/07/2003

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805135162888

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	275.00
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: 275.00

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 8/17/2016

42. Months of Treatment: 14

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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

CONNORS, JAMES
8100 LASATER RD
CLEMMONS, NC 27012-8442

13. Date of Birth (MM/DD/CCYY): 11/25/1962

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): W13694291

16. Plan/Group Number: 080960

17. Employer Name: RAI

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

CONNORS, RYAN P
8100 LASATER RD
CLEMMONS, NC 27012-8442

21. Date of Birth (MM/DD/CCYY): 01/16/2002

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 805137162887

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	239.50
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: 239.50

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 8/19/2016

42. Months of Treatment: 16

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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

CULLER, DEBORAH E
324 FARMBROOK RD
MOUNT AIRY, NC 27030-5748

13. Date of Birth (MM/DD/CCYY): 01/21/1965
14. Gender: [ ] M [X] F
15. Policyholder/Subscriber ID (SSN or ID#): W13694685
16. Plan/Group Number: 080960
17. Employer Name: RAI

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

CULLER, ADAM B
324 FARMBROOK RD
MOUNT AIRY, NC 27030-5748

21. Date of Birth (MM/DD/CCYY): 01/07/2003
22. Gender: [X] M [ ] F
23. Patient ID/Account # (Assigned by Dentist): 805121162886

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	266.11
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: 266.11

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 6/13/2016
42. Months of Treatment: 12
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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421
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: 903HC

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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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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

HAUSER, GREGORY
521 DODSON MILL ROAD
PILOT MOUNTAIN, NC 27041

13. Date of Birth (MM/DD/CCYY): 11/20/1952

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): W13690898

16. Plan/Group Number: 080960

17. Employer Name: RAI

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

HAUSER, CHARLOTTE ANN
521 DODSON MILL ROAD
PILOT MOUNTAIN, NC 27041

21. Date of Birth (MM/DD/CCYY): 05/04/2005

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805125162885

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	197.33
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: 197.33

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 6/30/2016

42. Months of Treatment: 25

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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

STEELMAN, TIMOTHY J
272 SADDLECHASE LN
WINSTON-SALEM, NC 27107

13. Date of Birth (MM/DD/CCYY): 04/26/1976

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): W13695421

16. Plan/Group Number: 080960

17. Employer Name: RAI

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

STEELMAN, JACEY
272 SADDLECHASE LN
WINSTON-SALEM, NC 27107

21. Date of Birth (MM/DD/CCYY): 11/11/2004

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805128162884

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	199.58
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: 199.58

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 6/9/2016

42. Months of Treatment: 23

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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

KING, GREGORY S
2515 MOCK ROAD
HIGH POINT, NC 27265

13. Date of Birth (MM/DD/CCYY): 12/04/1963
14. Gender: [X] M [ ] F
15. Policyholder/Subscriber ID (SSN or ID#): W13693691
16. Plan/Group Number: 080960
17. Employer Name: RAI

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

KING, BEN S
2515 MOCK ROAD
HIGH POINT, NC 27265

21. Date of Birth (MM/DD/CCYY): 08/05/2003
22. Gender: [X] M [ ] F
23. Patient ID/Account # (Assigned by Dentist): 805158162883

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	206.25
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: 206.25

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 10/6/2016
42. Months of Treatment: 22
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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421
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: 903HC

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or go online at adacatalog.org

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
   BLUE CROSS BLUE SHIELD OF NC
   P O BOX 2100
   WINSTON-SALEM, NC 27102

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

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
    SORRELL, GREGORY
    4280 VIKING DR
    WINSTON SALEM, NC 27105

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Policyholder/Subscriber ID (SSN or ID#)
09/07/1962	[X] M [ ] F	W16452681

16. Plan/Group Number	17. Employer Name
081501	BCBS

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

4. Dental? [X] Medical? [ ] (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
   REGINA SORRELL

6. Date of Birth (MM/DD/CCYY)	7. Gender	8. Policyholder/Subscriber ID (SSN or ID#)
12/18/1970	[ ] M [X] F	24546735

9. Plan/Group Number	10. Patient's Relationship to Person named in #5
00003558	[ ] Self [ ] Spouse [X] Dependent [ ] Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code
    INTERACTIVE MEDICAL SYSTEMS
    PO BOX 1349
    WAKE FOREST, NC 27588

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
    SORRELL, TAYLOR
    4280 VIKING DR
    WINSTON SALEM, NC 27105

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
06/20/2003	[X] M [ ] F	805141162882

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	199.58
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 199.58
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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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) 8/19/2016
42. Months of Treatment 23
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	50. License Number	51. SSN or TIN
1144309410	4151	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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI 1790716421
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 903HC

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or go online at adacatalog.org

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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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

GATEAU-CARRINGTON, BARBARA
5372 KINGSWELL DR
WINSTON SALEM, NC 27106

13. Date of Birth (MM/DD/CCYY): 06/02/1970

14. Gender: [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#): W14309860

16. Plan/Group Number: 009424

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

GATEAU-CARRINGTON, LARRIE
5372 KINGSWELL DR
WINSTON SALEM, NC 27106

21. Date of Birth (MM/DD/CCYY): 08/10/2005

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805148162881

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	192.00
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: 192.00

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: 11/28/2016

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: 11/28/2016

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): 9/6/2016

42. Months of Treatment: 27

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

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54. NPI: 1790716421

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: 903HC

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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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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

SHIELDS, ROBERT
2707 GLENHAVEN LN
WINSTON SALEM, NC 27106-2318

13. Date of Birth (MM/DD/CCYY): 09/23/1970

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): W13693343

16. Plan/Group Number: 080960

17. Employer Name: RA

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

SHIELDS, DEVIN I
2707 GLENHAVEN LN
WINSTON SALEM, NC 27106-2318

21. Date of Birth (MM/DD/CCYY): 03/11/2001

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 805149162880

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	199.58
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: 199.58

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.

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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 — 11/28/2016 — Date

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): 9/1/2016

42. Months of Treatment: 21

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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

DARDEN, CRAIG
155 RIDGE GATE CT
LEWISVILLE, NC 27023

13. Date of Birth (MM/DD/CCYY): 02/23/1968

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): W13694415

16. Plan/Group Number: 080960

17. Employer Name: RAI

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

DARDEN, JONATHAN
155 RIDGE GATE CT
LEWISVILLE, NC 27023

21. Date of Birth (MM/DD/CCYY): 11/12/2002

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 805154162879

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	247.50
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: 247.50

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 9/28/2016

42. Months of Treatment: 17

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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

HILL, STEPHEN V
2804 FRIEDLAND CHURCH RD
WINSTON SALEM, NC 27107

13. Date of Birth (MM/DD/CCYY): 08/08/1958

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): W13692684

16. Plan/Group Number: 080960

17. Employer Name: RAI

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

HILL, MORGAN L
2804 FRIEDLAND CHURCH RD
WINSTON SALEM, NC 27107

21. Date of Birth (MM/DD/CCYY): 09/08/2000

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805156162878

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	206.25
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: 206.25

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 9/30/2016

42. Months of Treatment: 21

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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

DOWNS, DAVID
3931 TALCOTT AVE
WINSTON SALEM, NC 27106

13. Date of Birth (MM/DD/CCYY): 04/13/1980

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): W16727917

16. Plan/Group Number: 075149

17. Employer Name: BCBS

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

DOWNS, MASIE
3931 TALCOTT AVE
WINSTON SALEM, NC 27106

21. Date of Birth (MM/DD/CCYY): 02/09/2003

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805157162877

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	239.50
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: 239.50

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 10/5/2016

42. Months of Treatment: 18

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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	8. Policyholder/Subscriber ID (SSN or ID#)
	[ ] M [ ] F	

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

ANTHONY, KEGRIS
830 BITTING CIIR
RURAL HALL, NC 27045

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Policyholder/Subscriber ID (SSN or ID#)
08/29/1984	[ ] M [X] F	W16000258

16. Plan/Group Number	17. Employer Name
008557	BCBS

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

ANTHONY, QUIANA
830 BITTING CIIR
RURAL HALL, NC 27045

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
11/30/2003	[ ] M [X] F	805169162876

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	266.11
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 266.11

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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) 10/20/2016

42. Months of Treatment 16

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	50. License Number	51. SSN or TIN
1144309410	4151	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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI 1790716421

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 903HC

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or go online at adacatalog.org

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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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

CALIFF, MARK K
7612 SEDGEWICK RIDGE RD
LEWISVILLE, NC 27023

13. Date of Birth (MM/DD/CCYY): 08/06/1970

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): W13694118

16. Plan/Group Number: 080960

17. Employer Name: RAI

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

CALIFF, KENSLEA L
7612 SEDGEWICK RIDGE RD
LEWISVILLE, NC 27023

21. Date of Birth (MM/DD/CCYY): 06/30/2004

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805111162875

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	199.58
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: 199.58

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 4/20/2016

42. Months of Treatment: 16

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) — 11/28/2016 — Date

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

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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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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

POWELL, MANDY K
101 BRITTANY CT
KING, NC 27021-8806

13. Date of Birth (MM/DD/CCYY): 09/03/1972

14. Gender: [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#): W13694602

16. Plan/Group Number: 080960

17. Employer Name: RAI

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

POWELL, ELLA
101 BRITTANY CT
KING, NC 27021-8806

21. Date of Birth (MM/DD/CCYY): 06/24/2004

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805117162874

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	206.25
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: 206.25

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 5/4/2016

42. Months of Treatment: 17

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) — 11/28/2016 — Date

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

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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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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

POTTS, RYAN J
145 NORWOOD FOREST LANE
TOBACCOVILLE, NC 27050

13. Date of Birth (MM/DD/CCYY): 11/06/1973

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): W13694289

16. Plan/Group Number: 080960

17. Employer Name: RAI

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

POTTS, ELLIE J
5010 MAYBERRY LANE
WINSTON-SALEM, NC 27106

21. Date of Birth (MM/DD/CCYY): 04/28/2004

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805070162873

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	206.25
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: 206.25

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 1/5/2016

42. Months of Treatment: 12

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) — 11/28/2016 — Date

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

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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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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

CLYBURN, JAMES
7457 PRINCESS ANN CT
RURAL HALL, NC 27045-9821

13. Date of Birth (MM/DD/CCYY): 01/14/1976

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): W13693826

16. Plan/Group Number: 080960

17. Employer Name: RAI

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

CLYBURN, JUSTIN A
7457 PRINCESS ANN CT
RURAL HALL, NC 27045-9821

21. Date of Birth (MM/DD/CCYY): 05/07/2004

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 805099162872

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	159.67
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: 159.67

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 3/22/2016

42. Months of Treatment: 12

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) — 11/28/2016 — Date

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

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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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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

BYRD, CRYSTAL H
603 GEORGE HEGE RD
LEXINGTON, NC 27295-7064

13. Date of Birth (MM/DD/CCYY): 05/16/1976

14. Gender: [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#): W13695485

16. Plan/Group Number: 080960

17. Employer Name: RAI

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

BYRD, KENDALL J
603 GEORGE HEGE RD
LEXINGTON, NC 27295-7064

21. Date of Birth (MM/DD/CCYY): 07/26/2001

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805087162871

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	206.25
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: 206.25

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 3/10/2016

42. Months of Treatment: 16

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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To reorder call 800.947.4746 or go online at adacatalog.org

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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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	8. Policyholder/Subscriber ID (SSN or ID#)
	[ ] M [ ] F	

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

CERNY, ERNEST
1742 MUDDY CREEK ROAD
CLEMMONS, NC 27012

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Policyholder/Subscriber ID (SSN or ID#)
12/13/1972	[X] M [ ] F	W13695683

16. Plan/Group Number	17. Employer Name
080960	RAI

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above	19. Reserved For Future Use
[ ] Self [ ] Spouse [X] Dependent Child [ ] Other	

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

CERNY, HUNTER
1742 MUDDY CREEK ROAD
CLEMMONS, NC 27012

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
06/01/2002	[X] M [ ] F	805075162870

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	206.25
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 206.25

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 11/28/2016
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 SIGNATURE ON FILE 11/28/2016
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")	39. Enclosures (Y or N)
11	[ ]

40. Is Treatment for Orthodontics?	41. Date Appliance Placed (MM/DD/CCYY)
[ ] No (Skip 41-42) [X] Yes (Complete 41-42)	12/17/2015

42. Months of Treatment	43. Replacement of Prosthesis	44. Date of Prior Placement (MM/DD/CCYY)
12	[ ] No [ ] Yes (Complete 44)	

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	50. License Number	51. SSN or TIN
1144309410	4151	56-2132966

52. Phone Number	52a. Additional Provider ID
(336) 331-3500	

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. Martin Slominski 11/28/2016
Signed (Treating Dentist) Date

54. NPI	55. License Number
1790716421	

56. Address, City, State, Zip Code	56a. Provider Specialty Code
201 Charlois Blvd Winston-Salem, NC 27103	1223X0400X

57. Phone Number	58. Additional Provider ID
(336) 331-3500	903HC

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or go online at adacatalog.org

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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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

HOLDEN, WESLEY
157 W VERNON CHURCH RD
WINSTON-SALEM, NC 27107

13. Date of Birth (MM/DD/CCYY): 12/11/1970

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): W16384728

16. Plan/Group Number: 080960

17. Employer Name: RAI

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

HOLDEN, TYLER R
157 W VERNON CHURCH RD
WINSTON-SALEM, NC 27107

21. Date of Birth (MM/DD/CCYY): 11/28/2002

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 805057162869

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	199.58
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: 199.58

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 10/27/2015

42. Months of Treatment: 10

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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

BARNES, FREDERICK
510 MARTHA CT
KERNERSVILLE, NC 27284-9748

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Policyholder/Subscriber ID (SSN or ID#)
02/28/1966	[X] M [ ] F	W13692709

16. Plan/Group Number	17. Employer Name
080960	RAI

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

BARNES, CAMERON I
510 MARTHA CT
KERNERSVILLE, NC 27284-9748

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
03/07/2003	[X] M [ ] F	805058162868

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	199.58
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 199.58

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 11/28/2016
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 SIGNATURE ON FILE 11/28/2016
Subscriber Signature Date

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) 12/29/2015

42. Months of Treatment 14

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	50. License Number	51. SSN or TIN
1144309410	4151	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. Martin Slominski 11/28/2016
Signed (Treating Dentist) Date

54. NPI 1790716421

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 903HC

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or go online at adacatalog.org

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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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

MABE, JEREMY
730 MT OLIVET CHURCH RD
LEXINGTON, NC 27295

13. Date of Birth (MM/DD/CCYY): 10/18/1974

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): W13694938

16. Plan/Group Number: 080960

17. Employer Name: RAI

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

MABE, OLIVIA G
730 MT OLIVET CHURCH RD
LEXINGTON, NC 27295

21. Date of Birth (MM/DD/CCYY): 04/28/2003

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805025162867

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	206.25
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: 206.25

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 6/2/2015

42. Months of Treatment: 6

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) — 11/28/2016 — Date

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

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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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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

LAWSON, AMANDA M
6457 UNIVERSITY PARKWAY
RURAL HALL, NC 27045

13. Date of Birth (MM/DD/CCYY): 06/06/1971

14. Gender: [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#): W14398942

16. Plan/Group Number: 008557

17. Employer Name: BCBS OF NC

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

LAWSON, RYLEY
6457 UNIVERSITY PARKWAY
RURAL HALL, NC 27045

21. Date of Birth (MM/DD/CCYY): 08/07/2003

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 800511162866

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	206.25
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: 206.25

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 3/11/2015

42. Months of Treatment: 3

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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

HOWARD, DAVID P
1611 JUBILEE TRAIL
KERNERSVILLE, NC 27284

13. Date of Birth (MM/DD/CCYY): 11/28/1966

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): W13694977

16. Plan/Group Number: 080960

17. Employer Name: RAI

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

HOWARD, DUNCAN P
1611 JUBILEE TRAIL
KERNERSVILLE, NC 27284

21. Date of Birth (MM/DD/CCYY): 06/27/2002

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 802161162865

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	199.58
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: 199.58

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 6/9/2014

42. Months of Treatment: 13

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) — 11/28/2016 — Date

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

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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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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

EUBANKS, DARREN
1140 REYNOLDS PRICE DR
KERNERSVILLE, NC 27284

13. Date of Birth (MM/DD/CCYY): 05/15/1971

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): W13694793

16. Plan/Group Number: 080960

17. Employer Name: RAI

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

EUBANKS, PAYTON
1140 REYNOLDS PRICE DR
KERNERSVILLE, NC 27284

21. Date of Birth (MM/DD/CCYY): 10/26/2002

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 802425162864

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	206.25
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: 206.25

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 8/3/2016

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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

WILLIAMS, AARON
1041 BROOKEMEADE DR
WINSTON-SALEM, NC 27106

13. Date of Birth (MM/DD/CCYY): 08/09/1971

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): W13694306

16. Plan/Group Number: 080960

17. Employer Name: RAI

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

WILLIAMS, AUSTIN C
1041 BROOKEMEADE DR
WINSTON-SALEM, NC 27106

21. Date of Birth (MM/DD/CCYY): 01/10/2001

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 802429162863

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	199.58
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: 199.58

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 1/21/2016

42. Months of Treatment: 13

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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

JONES, JESSE M
165 BROADMOOR DRIVE
ADVANCE, NC 27006

13. Date of Birth (MM/DD/CCYY): 01/24/1968

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): W14092923

16. Plan/Group Number: 080960

17. Employer Name: RAI

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

JONES, SAMUEL M.
165 BROADMOOR DRIVE
ADVANCE, NC 27006

21. Date of Birth (MM/DD/CCYY): 04/05/2000

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 801281162862

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	180.00
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: 180.00

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 4/7/2014

42. Months of Treatment: 0

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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	8. Policyholder/Subscriber ID (SSN or ID#)
	[ ] M [ ] F	

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

DELOACH, KENNETH C
7470 COON CREEK ROAD
PFAFFTOWN, NC 27040

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Policyholder/Subscriber ID (SSN or ID#)
07/29/1971	[X] M [ ] F	W13695675

16. Plan/Group Number	17. Employer Name
080960	RAI

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above	19. Reserved For Future Use
[ ] Self [ ] Spouse [X] Dependent Child [ ] Other	

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

DELOACH, THOMAS
7470 COON CREEK ROAD
PFAFFTOWN, NC 27040

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
04/16/2002	[X] M [ ] F	803094162861

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	206.25
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 206.25

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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) 10/24/2014

42. Months of Treatment 0

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	50. License Number	51. SSN or TIN
1144309410	4151	56-2132966

52. Phone Number	52a. Additional Provider ID
(336) 331-3500	

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI	55. License Number
1790716421	

56. Address, City, State, Zip Code	56a. Provider Specialty Code
201 Charlois Blvd Winston-Salem, NC 27103	1223X0400X

57. Phone Number	58. Additional Provider ID
(336) 331-3500	903HC

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or go online at adacatalog.org

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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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

CLARK, MELISSA
295 CANYON ROAD
MOCKSVILLE, NC 27028

13. Date of Birth (MM/DD/CCYY): 08/19/1970

14. Gender: [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#): W13694802

16. Plan/Group Number: 080960

17. Employer Name: RAI

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

CLARK, MADELINE
295 CANYON ROAD
MOCKSVILLE, NC 27028

21. Date of Birth (MM/DD/CCYY): 06/04/2001

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805046162860

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	179.03
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: 179.03

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 8/26/2015

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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

HANELINE, RICKY G
200 MIDBROOK RUN
LEXINGTON, NC 27295-5616

13. Date of Birth (MM/DD/CCYY): 09/14/1958

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): W13693675

16. Plan/Group Number: 080960

17. Employer Name: RAI

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

HANELINE, CASSIDY C
200 MIDBROOK RUN
LEXINGTON, NC 27295-5616

21. Date of Birth (MM/DD/CCYY): 06/26/2002

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805050162859

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	228.10
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: 228.10

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 9/3/2015

42. Months of Treatment: 6

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) — 11/28/2016 — Date

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

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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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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

MOCK, WAYNE H
170 RIDGEWAY LN
LEXINGTON, NC 27295

13. Date of Birth (MM/DD/CCYY): 08/15/1957

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): W13693664

16. Plan/Group Number: 080960

17. Employer Name: RAI

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

MOCK, RILEY C
170 RIDGEWAY LN
LEXINGTON, NC 27295

21. Date of Birth (MM/DD/CCYY): 08/09/2000

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 800524162858

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	206.25
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: 206.25

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 4/15/2015

42. Months of Treatment: 4

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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

WILLIAMS, CRYSTAL B
420 FORD STREET
YADKINVILLE, NC 27055

13. Date of Birth (MM/DD/CCYY): 11/12/1971

14. Gender: [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#): W13693825

16. Plan/Group Number: 080960

17. Employer Name: RAI

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

WILLIAMS, JARED M
420 FORD STREET
YADKINVILLE, NC 27055

21. Date of Birth (MM/DD/CCYY): 01/05/2001

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 805053162857

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	266.11
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: 266.11

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 11/25/2015

42. Months of Treatment: 6

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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

WILLIAMSON, CHRISTINA
7644 PENLAND DRIVE
CLEMMONS, NC 27012-8457

13. Date of Birth (MM/DD/CCYY): 04/16/1971

14. Gender: [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#): W13695966

16. Plan/Group Number: 080960

17. Employer Name: RAI

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

LUCERO, BRIANNA E
7644 PENLAND DRIVE
CLEMMONS, NC 27012-8457

21. Date of Birth (MM/DD/CCYY): 02/23/2001

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805040162856

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	206.25
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: 206.25

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: 11/28/2016

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: 11/28/2016

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): 8/19/2015

42. Months of Treatment: 8

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. Martin Slominski — Signed (Treating Dentist) — Date: 11/28/2016

54. NPI: 1790716421

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: 903HC

©2012 American Dental Association

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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

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

QUIGGLE, STEVEN A
5885 COTTONWOOD LN
WINSTON-SALEM, NC 27103

13. Date of Birth (MM/DD/CCYY): 06/01/1956

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): W13694422

16. Plan/Group Number: 081769

17. Employer Name: WIELAND COPPER PRODUCTS

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

QUIGGLE, KATIE J
5885 COTTONWOOD LN
WINSTON-SALEM, NC 27103

21. Date of Birth (MM/DD/CCYY): 12/16/1999

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805028162855

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	206.25
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: 206.25

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 6/18/2015

42. Months of Treatment: 6

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

CIGNA
PO BOX 188037
CHATTANOOGA, TN 37422-8037

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	8. Policyholder/Subscriber ID (SSN or ID#)
	[ ] M [ ] F	

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

PRIEBE, ROBERT
4807 TIFFANY AVE
WINSTON SALEM, NC 27104

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Policyholder/Subscriber ID (SSN or ID#)
09/22/1962	[X] M [ ] F	U03809751

16. Plan/Group Number	17. Employer Name
2499247	FEDEX

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above	19. Reserved For Future Use
[ ] Self [ ] Spouse [X] Dependent Child [ ] Other	

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

PRIEBE, MICHAEL A
234 HAVENWOOD DRIVE
WINSTON SALEM, NC 27127-9050

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
06/29/2002	[X] M [ ] F	805052162854

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	149.68
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 149.68

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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) 9/10/2015

42. Months of Treatment 9

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	50. License Number	51. SSN or TIN
1144309410	4151	56-2132966

52. Phone Number	52a. Additional Provider ID
(336) 331-3500	

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) — 11/28/2016 — Date

54. NPI	55. License Number
1457441420	

56. Address, City, State, Zip Code	56a. Provider Specialty Code
201 Charlois Blvd Winston-Salem, NC 27103	1223X0400X

57. Phone Number	58. Additional Provider ID
(336) 331-3500	

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or go online at adacatalog.org

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

CIGNA
P O BOX 188037
CHATTANOOGA, TN 37422

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

OXENDINE, MARY
1257 TERRY RD
WINSTON-SALEM, NC 27107

13. Date of Birth (MM/DD/CCYY): 08/07/1975

14. Gender: [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#): U58859672

16. Plan/Group Number: 3215072

17. Employer Name: KINDRED HEALTHCARE

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

CARTER, CHANCELLOR
1257 TERRY RD
WINSTON-SALEM, NC 27107

21. Date of Birth (MM/DD/CCYY): 02/20/2002

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 803130162853

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	140.62
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: 140.62

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 9/24/2014

42. Months of Treatment: 0

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

CIGNA
P O BOX 188037
CHATTANOOGA, TN 37422

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

TORRES, JORGE
1242 FOLKSTONE RIDGE LN
WINSTON SALEM, NC 27127

13. Date of Birth (MM/DD/CCYY): 08/12/1983

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): 001710352

16. Plan/Group Number: 00058856603

17. Employer Name: LOWE'S COMPANIES, INC

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

TORRES, JACOB
1242 FOLKSTONE RIDGE LN
WINSTON SALEM, NC 27127

21. Date of Birth (MM/DD/CCYY): 05/26/2002

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 805064162852

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	148.00
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: 148.00

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: 11/28/2016

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: 11/28/2016

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): 10/28/2015

42. Months of Treatment: 16

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. Martin Slominski — Signed (Treating Dentist) — Date: 11/28/2016

54. NPI: 1790716421

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: 903HC

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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

Cigna
P O Box 188047
Chattanooga, TN 37422

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

REDMOND, SANDRA
9015 BOBBITT WAY
CHARLOTTE, NC 28216

13. Date of Birth (MM/DD/CCYY): 01/18/1976

14. Gender [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#): U02529737

16. Plan/Group Number: 10079347

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

REDMOND-WEBSTER, RASHAWN
9015 BOBBITT WAY
CHARLOTTE, NC 28216

21. Date of Birth (MM/DD/CCYY): 04/23/1996

22. Gender [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 805083162851

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	199.58
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: 199.58

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 1/20/2016

42. Months of Treatment: 13

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

CIGNA
P O BOX 188037
CHATTANOOGA, TN 37422

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

THOMPSON, SHANNON
145 STILLMERE COURT
WINSTON-SALEM, NC 27101

13. Date of Birth (MM/DD/CCYY): 03/20/1977

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): U61121222

16. Plan/Group Number: 2458462

17. Employer Name: MASS MUTUTAL FINANCIAL

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

THOMPSON, JORDYN
145 STILLMERE COURT
WINSTON-SALEM, NC 27101

21. Date of Birth (MM/DD/CCYY): 03/01/2003

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805093162850

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	140.62
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: 140.62

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 4/13/2016

42. Months of Treatment: 16

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) — 11/28/2016 — Date

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

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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

CIGNA
P O BOX 188037
CHATTANOOGA, TN 37422

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

CLARK, JAVAR
4333 GROVE AVE APT C
WINSTON-SALEM, NC 27105

13. Date of Birth (MM/DD/CCYY): 10/13/1976

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): U52262636

16. Plan/Group Number: 2490738

17. Employer Name: CATERPILLAR

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

ROBERTS, TAMIA S
4333 GROVE AVE APT C
WINSTON-SALEM, NC 27105

21. Date of Birth (MM/DD/CCYY): 03/18/2001

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805100162849

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	149.68
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: 149.68

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 5/10/2016

42. Months of Treatment: 17

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

CIGNA
P O BOX 188037
CHATTANOOGA, TN 37422

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

ALLEN, HEATHER
396 EAST DALTON RD
KING, NC 27021

13. Date of Birth (MM/DD/CCYY): 10/12/1975

14. Gender: [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#): 102881164

16. Plan/Group Number: 00745543

17. Employer Name: IMG WORLDWIDE

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

ALLEN, SARAH
396 EAST DALTON RD
KING, NC 27021

21. Date of Birth (MM/DD/CCYY): 12/02/2002

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805103162848

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	199.58
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: 199.58

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 4/14/2016

42. Months of Treatment: 10

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

Delta Dental of RI
P O Box 1517
Providence, RI 02901-1517

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

INGRAM, DEANNA
1677 OLD HOLLOW RD
WINSTON-SALEM, NC 27105

13. Date of Birth (MM/DD/CCYY): 07/15/1979

14. Gender: [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#): 0002223529

16. Plan/Group Number: 7000-0001

17. Employer Name: CVS HEALTH

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

INGRAM, ELIJAH
3566 THORNABY CIRCLE
WINSTON-SALEM, NC 27107

21. Date of Birth (MM/DD/CCYY): 11/27/2000

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 803106162847

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	87.50
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: 87.50

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 11/3/2014

42. Months of Treatment: 6

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

DELTAL DENTAL OF MI
PO BOX 9085
FARMINGTON HILLS, MI 48333

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	8. Policyholder/Subscriber ID (SSN or ID#)
	[ ] M [ ] F	

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

LITTLE, VICTOR
2275 BRIAR GLENN RD
WINSTON-SALEM, NC 27127

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Policyholder/Subscriber ID (SSN or ID#)
10/30/1971	[X] M [ ] F	253618331

16. Plan/Group Number	17. Employer Name
0024-0001	VERTELLUS

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above	19. Reserved For Future Use
[ ] Self [ ] Spouse [X] Dependent Child [ ] Other	

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

LITTLE, PEYTON A
2275 BRIAR GLENN RD
WINSTON-SALEM, NC 27127

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
09/21/2001	[X] M [ ] F	805129162846

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	199.58
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 199.58

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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) 7/21/2016

42. Months of Treatment 19

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	50. License Number	51. SSN or TIN
1144309410	4151	56-2132966

52. Phone Number	52a. Additional Provider ID
(336) 331-3500	

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) — 11/28/2016 — Date

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	58. Additional Provider ID
(336) 331-3500	

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To reorder call 800.947.4746
or go online at adacatalog.org

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

INTERACTIVE MEDICAL SYSTEMS
PO BOX 1349
WAKE FOREST, NC 27588

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

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

FERNANDEZ, SARA
3116 GREENE CROSS DR
WINSTON SALEM, NC 27107

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Policyholder/Subscriber ID (SSN or ID#)
03/21/1976	[ ] M [X] F	035661381

16. Plan/Group Number	17. Employer Name
3558	

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	8. Policyholder/Subscriber ID (SSN or ID#)
	[ ] M [ ] F	

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

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above	19. Reserved For Future Use
[X] Self [ ] Spouse [ ] Dependent Child [ ] Other	

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

FERNANDEZ, SARA
WINSTON SALEM, NC 27107

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
03/21/1976	[ ] M [X] F	805091162845

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	356.67
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 356.67

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 11/28/2016
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 SIGNATURE ON FILE 11/28/2016
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")	39. Enclosures (Y or N)
11	[ ]

40. Is Treatment for Orthodontics?	41. Date Appliance Placed (MM/DD/CCYY)
[ ] No (Skip 41-42) [X] Yes (Complete 41-42)	2/8/2016

42. Months of Treatment	43. Replacement of Prosthesis	44. Date of Prior Placement (MM/DD/CCYY)
5	[ ] No [ ] Yes (Complete 44)	

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	50. License Number	51. SSN or TIN
1144309410	4151	56-2132966

52. Phone Number	52a. Additional Provider ID
(336) 331-3500	

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. Martin Slominski 11/28/2016
Signed (Treating Dentist) Date

54. NPI	55. License Number
1790716421	

56. Address, City, State, Zip Code	56a. Provider Specialty Code
201 Charlois Blvd Winston-Salem, NC 27103	1223X0400X

57. Phone Number	58. Additional Provider ID
(336) 331-3500	903HC

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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

INTERACTIVE MEDICAL SYSTEMS
PO BOX 1349
WAKE FOREST, NC 27588

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

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

URIZAR, SARA
3116 GREENE CROSS DR
WINSTON SALEM, NC 27107

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Policyholder/Subscriber ID (SSN or ID#)
03/21/1976	[ ] M [X] F	035661381

16. Plan/Group Number	17. Employer Name
3558	GUILFORD COUNTY

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	8. Policyholder/Subscriber ID (SSN or ID#)
	[ ] M [ ] F	

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

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above	19. Reserved For Future Use
[ ] Self [ ] Spouse [X] Dependent Child [ ] Other	

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

URIZAR-ARIAS, JOSHABET
3116 GREENE CROSS DR
WINSTON SALEM, NC 27107

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
10/10/2003	[ ] M [X] F	805061162844

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	125.00
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 125.00

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 11/28/2016
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 SIGNATURE ON FILE 11/28/2016
Subscriber Signature Date

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) 10/2/2015

42. Months of Treatment 24

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	50. License Number	51. SSN or TIN
1144309410	4151	56-2132966

52. Phone Number	52a. Additional Provider ID
(336) 331-3500	

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. Martin Slominski 11/28/2016
Signed (Treating Dentist) Date

54. NPI	55. License Number
1790716421	

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

56a. Provider Specialty Code 1223X0400X

57. Phone Number	58. Additional Provider ID
(336) 331-3500	903HC

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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

MEDCOST
PO BOX 25987
WINSTON-SALEM, NC 27114

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

NIXON, HOPE
3740 WESTWOOD RD
HAMPTONVILLE, NC 27020

13. Date of Birth (MM/DD/CCYY): 06/11/1976

14. Gender: [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#): A0005184904

16. Plan/Group Number: 3365

17. Employer Name: WFUBMC

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

NIXON, LUCAS
3740 WESTWOOD RD
HAMPTONVILLE, NC 27020

21. Date of Birth (MM/DD/CCYY): 07/05/2003

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 802185162843

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	199.58
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: 199.58

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 9/15/2015

42. Months of Treatment: 9

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) — 11/28/2016 — Date

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

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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

MEDCOST BENEFIT SERVICES
PO BOX 25987
WINSTON SALEM, NC 27114

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

BROWN, JACQUELINE S
3421 OLD VINEYARD RD APT C39
WINSTON SALEM, NC 27103

13. Date of Birth (MM/DD/CCYY): 03/07/1991

14. Gender: [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#): A0131720700

16. Plan/Group Number: 3372

17. Employer Name: WFUBMC

PATIENT INFORMATION

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

19. Reserved For Future Use

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

BROWN, JACQUELINE S
APT C39
WINSTON SALEM, NC 27103

21. Date of Birth (MM/DD/CCYY): 03/07/1991

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805029162842

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	297.22
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: 297.22

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: 11/28/2016

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: 11/28/2016

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): 8/10/2015

42. Months of Treatment: 2

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. Martin Slominski — Signed (Treating Dentist) — Date: 11/28/2016

54. NPI: 1790716421

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: 903HC

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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

MEDCOST BENEFIT SERVICES
PO BOX 25987
WINSTON SALEM, NC 27114

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

HARPE-HALL, STACY B
1212 HORSESHOE NECK ROAD
LEXINGTON, NC 27295

13. Date of Birth (MM/DD/CCYY): 04/04/1974

14. Gender: [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#): A0004029200

16. Plan/Group Number: 3372

17. Employer Name: WFUBMC

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

HARPE, NATALIE G
1212 HORSESHOE NECK ROAD
LEXINGTON, NC 27295

21. Date of Birth (MM/DD/CCYY): 03/20/2003

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805060162841

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	206.25
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: 206.25

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 10/7/2015

42. Months of Treatment: 10

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

MEDCOST BENEFIT SERVICES
PO BOX 25987
WINSTON SALEM, NC 27114

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

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

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

KENNETH L KIRK

6. Date of Birth (MM/DD/CCYY)	7. Gender	8. Policyholder/Subscriber ID (SSN or ID#)
09/02/1969	[X] M [ ] F	230271222

9. Plan/Group Number	10. Patient's Relationship to Person named in #5
5995847	[ ] Self [ ] Spouse [X] Dependent [ ] Other

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

METLIFE
PO BOX 981282
EL PASO, TX 79998

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

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

KIRK, REGINA
6430 ROBINHOOD TRACE RD
WINSTON SALEM, NC 27106

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Policyholder/Subscriber ID (SSN or ID#)
04/05/1973	[ ] M [X] F	A0003036800

16. Plan/Group Number	17. Employer Name
3372	

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above	19. Reserved For Future Use
[ ] Self [ ] Spouse [X] Dependent Child [ ] Other	

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

KIRK, KIERSTYN
6430 ROBINHOOD TRACE RD
WINSTON SALEM, NC 27106

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
05/14/2002	[ ] M [X] F	805073162840

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	250.00
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 250.00

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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) 12/9/2015

42. Months of Treatment 7

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	50. License Number	51. SSN or TIN
1144309410	4151	56-2132966

52. Phone Number	52a. Additional Provider ID
(336) 331-3500	

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI 1790716421

55. License Number

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

56a. Provider Specialty Code 1223X0400X

57. Phone Number	58. Additional Provider ID
(336) 331-3500	903HC

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or go online at adacatalog.org

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

MEDCOST BENEFIT SERVICES
PO BOX 25987
WINSTON SALEM, NC 27114

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

TURNER, AQUILLA
152 BROOKHILL PARK CT
RURAL HALL, NC 27045-9634

13. Date of Birth (MM/DD/CCYY): 04/20/1980

14. Gender: [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#): A000960710

16. Plan/Group Number: 3372

17. Employer Name: WFBMC

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

NELSON, AMYA
152 BROOKHILL PARK CT
RURAL HALL, NC 27045-9634

21. Date of Birth (MM/DD/CCYY): 01/19/2001

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805133162839

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	199.58
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: 199.58

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 8/3/2016

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) — 11/28/2016 — Date

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

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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

MEDCOST BENEFIT SERVICES
PO BOX 25987
WINSTON SALEM, NC 27114

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	8. Policyholder/Subscriber ID (SSN or ID#)
	[ ] M [ ] F	

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

UPADHYA, BHARATHI
142 COVINGTON PLACE
LEWISVILLE, NC 27023

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Policyholder/Subscriber ID (SSN or ID#)
01/31/1971	[ ] M [X] F	A0008622700

16. Plan/Group Number	17. Employer Name
3372	WFBMC

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above	19. Reserved For Future Use
[ ] Self [ ] Spouse [X] Dependent Child [ ] Other	

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

UPADHYA, SURAJ
142 COVINGTON PLACE
LEWISVILLE, NC 27023

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
01/27/2001	[X] M [ ] F	805136162838

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	199.58
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 199.58

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 11/28/2016
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 SIGNATURE ON FILE 11/28/2016
Subscriber Signature Date

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) 8/16/2016

42. Months of Treatment 21

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	50. License Number	51. SSN or TIN
1144309410	4151	56-2132966

52. Phone Number	52a. Additional Provider ID
(336) 331-3500	

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. Martin Slominski 11/28/2016
Signed (Treating Dentist) Date

54. NPI	55. License Number
1790716421	

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

56a. Provider Specialty Code 1223X0400X

57. Phone Number	58. Additional Provider ID
(336) 331-3500	903HC

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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

JOHNSON, NASION
1340 WOODRUFF GLEN DR
WINSTON SALEM, NC 27105-4965

13. Date of Birth (MM/DD/CCYY): 12/25/1969

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): 001125400

16. Plan/Group Number: 37302

17. Employer Name: PEPSI

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

JOHNSON, NASION C
1340 WOODRUFF GLEN DR
WINSTON SALEM, NC 27105-4965

21. Date of Birth (MM/DD/CCYY): 11/16/2002

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 805140162837

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	164.00
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: 164.00

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 8/22/2016

42. Months of Treatment: 18

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

SMITH, JODY S
2900 PEAR ORCHARD RD
YADKINVILLE, NC 27055

13. Date of Birth (MM/DD/CCYY): 06/24/1968

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): 237250828

16. Plan/Group Number: 0306436

17. Employer Name: US AIRWAYS

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

SMITH, MEGAN N
2900 PEAR ORCHARD RD
YADKINVILLE, NC 27055

21. Date of Birth (MM/DD/CCYY): 11/30/2002

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805143162836

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	150.00
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: 150.00

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: 11/28/2016

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: 11/28/2016

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): 8/31/2016

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: 11/28/2016

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

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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	8. Policyholder/Subscriber ID (SSN or ID#)
	[ ] M [ ] F	

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

MARSHALL, RANDY D
1160 ERIC SHELTON RD
WESTFIELD, NC 27053-7328

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Policyholder/Subscriber ID (SSN or ID#)
08/12/1969	[X] M [ ] F	238499592

16. Plan/Group Number	17. Employer Name
300740	REXAM

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above	19. Reserved For Future Use
[ ] Self [ ] Spouse [X] Dependent Child [ ] Other	

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

MARSHALL, ISABELLE
1160 ERIC SHELTON RD
WESTFIELD, NC 27053-7328

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
08/12/2002	[ ] M [X] F	805144162835

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	172.00
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 172.00

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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) 9/27/2016

42. Months of Treatment 21

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	50. License Number	51. SSN or TIN
1144309410	4151	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) — 11/28/2016 — Date

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

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or go online at adacatalog.org

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

JOHNSON, DEANNA
244 LIVEOAK LANE
LEXINGTON, NC 27295

13. Date of Birth (MM/DD/CCYY): 08/29/1962

14. Gender: [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#): 235941894

16. Plan/Group Number: 104975

17. Employer Name: FORSYTHE TECHNOLOGY

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

JOHNSON, BRANDON
244 LIVEOAK LANE
LEXINGTON, NC 27295

21. Date of Birth (MM/DD/CCYY): 05/12/2003

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 805146162834

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	150.00
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: 150.00

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 8/18/2016

42. Months of Treatment: 26

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

MORRISON, CRAIG C
3561 CEDAR POST RD
WINSTON SALEM, NC 27127

13. Date of Birth (MM/DD/CCYY): 07/23/1965

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): 237353748

16. Plan/Group Number: 0143243

17. Employer Name: CITIGROUP

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

MORRISON, CAIDEN
3561 CEDAR POST RD
WINSTON SALEM, NC 27127

21. Date of Birth (MM/DD/CCYY): 07/28/2005

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 805134162833

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	122.00
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: 122.00

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 7/26/2016

42. Months of Treatment: 5

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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): 805131162832

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	140.63
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: 140.63

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

JONES, NERO T
5515 HIGHLAND TRACE CT
WINSTON-SALEM, NC 27105

13. Date of Birth (MM/DD/CCYY): 03/20/1974

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): 240219507

16. Plan/Group Number: 300740

17. Employer Name: REXAM

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

DIXON, GWENYTH J
5515 HIGHLAND TRACE CT
WINSTON-SALEM, NC 27105

21. Date of Birth (MM/DD/CCYY): 05/31/2003

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805127162831

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	150.00
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: 150.00

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 6/23/2016

42. Months of Treatment: 18

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) — 11/28/2016 — Date

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

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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

BRADSHAW, ROBIN G
222 BEECHWOOD CIRCLE
WINSTON SALEM, NC 27105

13. Date of Birth (MM/DD/CCYY): 03/12/1955

14. Gender: [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#): 239960520

16. Plan/Group Number: 302747

17. Employer Name

PATIENT INFORMATION

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

19. Reserved For Future Use

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

BRADSHAW, ROBIN G
222 BEECHWOOD CIRCLE
WINSTON SALEM, NC 27105

21. Date of Birth (MM/DD/CCYY): 03/12/1955

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805172162830

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	200.00
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: 200.00

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: 11/28/2016

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: 11/28/2016

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): 10/26/2016

42. Months of Treatment: 17

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: 11/28/2016

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

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or go online at adacatalog.org

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

MCELROY, ERIN
308 OAK GLEN DR
WINSTON SALEM, NC 27107

13. Date of Birth (MM/DD/CCYY): 05/30/1976

14. Gender: [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#): 200648678

16. Plan/Group Number: 305584

17. Employer Name: NOVANT HEALTH

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

MCELROY, MACKENZIE
308 OAK GLEN DR
WINSTON SALEM, NC 27107

21. Date of Birth (MM/DD/CCYY): 07/18/2003

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805150162829

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	150.00
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: 150.00

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 9/8/2016

42. Months of Treatment: 33

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

LIBUNAO, JENNIE
1350 ROSEWOOD CT
WINSTON-SALEM, NC 27103

13. Date of Birth (MM/DD/CCYY): 07/17/1967

14. Gender: [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#): 107762690

16. Plan/Group Number: 305584

17. Employer Name: NOVANT HEALTH

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

LIBUNAO, OWEN
1350 ROSEWOOD CT
WINSTON-SALEM, NC 27103

21. Date of Birth (MM/DD/CCYY): 03/12/2004

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 805167162828

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	150.00
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: 150.00

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 10/19/2016

42. Months of Treatment: 22

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) — 11/28/2016 — Date

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

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or go online at adacatalog.org

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

FLETCHER, DANIEL A
132 MOUNTAIN SHADOW LANE
KING, NC 27021

13. Date of Birth (MM/DD/CCYY): 01/10/1976

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): 237496777

16. Plan/Group Number: 138847

17. Employer Name: T E CONNECTIVITY LTD

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

FLETCHER, DEVIN A
132 MOUNTAIN SHADOW LANE
KING, NC 27021

21. Date of Birth (MM/DD/CCYY): 06/09/2001

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 805085162827

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	133.34
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: 133.34

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 2/17/2016

42. Months of Treatment: 17

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

MILLS, PIPER
1394 STONEGATE DRIVE
WINSTON-SALEM, NC 27107-9693

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Policyholder/Subscriber ID (SSN or ID#)
11/26/1972	[ ] M [X] F	245471533

16. Plan/Group Number	17. Employer Name
305584	N

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

MILLS, BRADEN P
1394 STONEGATE DR
WINSTON SALEM, NC 27107-9693

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
10/02/2001	[X] M [ ] F	805076162826

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	150.00
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 150.00

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 11/28/2016
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 SIGNATURE ON FILE 11/28/2016
Subscriber Signature Date

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) 1/7/2016

42. Months of Treatment 13

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	50. License Number	51. SSN or TIN
1144309410	4151	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 11/28/2016
Signed (Treating Dentist) Date

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

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or go online at adacatalog.org

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

HUNTER, THOMAS F
297 JU LENOR DR
WINSTON SALEM, NC 27107-8995

13. Date of Birth (MM/DD/CCYY): 09/11/1969

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): 239396839

16. Plan/Group Number: 143343

17. Employer Name: PIEDMONT NATURAL GAS

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

HUNTER, ALANA L
297 JU LENOR DR
WINSTON SALEM, NC 27107-8995

21. Date of Birth (MM/DD/CCYY): 09/17/2001

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805081162825

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	133.20
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: 133.20

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 1/12/2016

42. Months of Treatment: 14

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

ZUIDEMA, KEVIN A
923 RIDGEGATE DRIVE
LEWISVILLE, NC 27023

13. Date of Birth (MM/DD/CCYY): 01/13/1969

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): 001085584

16. Plan/Group Number: 83010

17. Employer Name: PEPSICO

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

ZUIDEMA, ANNALISE
923 RIDGEGATE DRIVE
LEWISVILLE, NC 27023

21. Date of Birth (MM/DD/CCYY): 10/03/2001

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805062162824

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	115.00
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: 115.00

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 11/11/2015

42. Months of Treatment: 5

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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

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

KEVIN ELLIS

6. Date of Birth (MM/DD/CCYY)	7. Gender	8. Policyholder/Subscriber ID (SSN or ID#)
04/08/1966	[X] M [ ] F	249154559

9. Plan/Group Number	10. Patient's Relationship to Person named in #5
112815	[ ] Self [ ] Spouse [X] Dependent [ ] Other

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

METLIFE
PO BOX 981282
EL PASO, TX 79998

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

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

ELLIS, JULIE
3720 BEESON DAIRY RD
WINSTON SALEM, NC 27105-9778

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Policyholder/Subscriber ID (SSN or ID#)
01/05/1969	[ ] M [X] F	240175290

16. Plan/Group Number	17. Employer Name
305584	NOVANT HEALTH

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above	19. Reserved For Future Use
[ ] Self [ ] Spouse [X] Dependent Child [ ] Other	

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

ELLIS, KELSEY
3720 BEESON DAIRY RD
WINSTON SALEM, NC 27105-9778

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
01/16/2003	[ ] M [X] F	805065162823

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	150.00
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 150.00

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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) 12/1/2015

42. Months of Treatment 12

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	50. License Number	51. SSN or TIN
1144309410	4151	56-2132966

52. Phone Number	52a. Additional Provider ID
(336) 331-3500	

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) — 11/28/2016 — Date

54. NPI	55. License Number
1457441420	

56. Address, City, State, Zip Code	56a. Provider Specialty Code
201 Charlois Blvd Winston-Salem, NC 27103	1223X0400X

57. Phone Number	58. Additional Provider ID
(336) 331-3500	

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or go online at adacatalog.org

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

LILLY, ROBERT
1055 STERLING POINT DR
KING, NC 27021

13. Date of Birth (MM/DD/CCYY): 12/04/1972

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): 238177354

16. Plan/Group Number: 138847

17. Employer Name: T E CONNECTIVITY LTD

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

LILLY, BRANDON G
1055 STERLING POINT DR
KING, NC 27021

21. Date of Birth (MM/DD/CCYY): 01/18/1997

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 805095162822

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	100.00
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: 100.00

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 3/3/2016

42. Months of Treatment: 16

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) — 11/28/2016 — Date

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

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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

DRAUGHN, MICHAEL H
2121 NEWCASTLE DR
WINSTON SALEM, NC 27103

13. Date of Birth (MM/DD/CCYY): 10/04/1967

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): 242903740

16. Plan/Group Number: 305584

17. Employer Name: NOVANT HEALTH

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

HALL, MADELYN J
2121 NEWCASTLE DR
WINSTON SALEM, NC 27103

21. Date of Birth (MM/DD/CCYY): 08/07/2005

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805104162821

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	76.00
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: 76.00

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 5/17/2016

42. Months of Treatment: 9

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) — 11/28/2016 — Date

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

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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

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

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

WILKINS, VINCENT O
2119 HOGAN POINT DRIVE
WINSTON-SALEM, NC 27127

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Policyholder/Subscriber ID (SSN or ID#)
03/28/1980	[X] M [ ] F	237473114

16. Plan/Group Number	17. Employer Name
312466	CONE HEALTH

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

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

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

MICHA JAMES

6. Date of Birth (MM/DD/CCYY)	7. Gender	8. Policyholder/Subscriber ID (SSN or ID#)
07/17/1981	[ ] M [X] F	W13765231

9. Plan/Group Number	10. Patient's Relationship to Person named in #5
081501	[ ] Self [ ] Spouse [X] Dependent [ ] Other

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

BLUE CROSS BLUE SHIELD OF NC
P O BOX 2100
WINSTON-SALEM, NC 27102

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above	19. Reserved For Future Use
[ ] Self [ ] Spouse [X] Dependent Child [ ] Other	

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

JAMES, MICHAI
2504 TANTELON PLACE
WINSTON-SALEM, NC 27127

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
08/07/2004	[X] M [ ] F	805110162820

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	150.00
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 150.00

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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) 3/30/2016

42. Months of Treatment 22

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	50. License Number	51. SSN or TIN
1144309410	4151	56-2132966

52. Phone Number	52a. Additional Provider ID
(336) 331-3500	

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) — 11/28/2016 — Date

54. NPI	55. License Number
1457441420	

56. Address, City, State, Zip Code	56a. Provider Specialty Code
201 Charlois Blvd Winston-Salem, NC 27103	1223X0400X

57. Phone Number	58. Additional Provider ID
(336) 331-3500	

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or go online at adacatalog.org

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

SMITH, LAURA
825 ERNEST SNIDER RD
LEXINGTON, NC 27292-9429

13. Date of Birth (MM/DD/CCYY): 10/26/1971

14. Gender: [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#): 246173868

16. Plan/Group Number: 305584

17. Employer Name: NOVANT HEALTH

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

SMITH, EMILY
825 ERNEST SNIDER RD
LEXINGTON, NC 27292-9429

21. Date of Birth (MM/DD/CCYY): 11/08/2001

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805107162819

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	150.00
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: 150.00

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: 11/28/2016

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: 11/28/2016

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): 4/4/2016

42. Months of Treatment: 16

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. Martin Slominski — Signed (Treating Dentist) — Date: 11/28/2016

54. NPI: 1790716421

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: 903HC

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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

ENGLISH, BETSY
240 GRANDVIEW DR
WINSTON SALEM, NC 27104-4122

13. Date of Birth (MM/DD/CCYY): 06/01/1963

14. Gender: [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#): 240233337

16. Plan/Group Number: 305584

17. Employer Name: NOVANT HEALTH

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

STANEK, ROMULUS
240 GRANDVIEW DR
WINSTON SALEM, NC 27104-4122

21. Date of Birth (MM/DD/CCYY): 08/10/2001

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 805119162818

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	200.00
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: 200.00

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 5/12/2016

42. Months of Treatment: 11

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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

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

KRISTI FRISBIE

6. Date of Birth (MM/DD/CCYY)	7. Gender	8. Policyholder/Subscriber ID (SSN or ID#)
10/27/1969	[ ] M [X] F	U36911731

9. Plan/Group Number	10. Patient's Relationship to Person named in #5
2499690	[ ] Self [ ] Spouse [X] Dependent [ ] Other

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

CIGNA
P O BOX 188037
CHATTANOOGA, TN 37422

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

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

FRISBIE, KEITH L
4436 GUMTREE RD
WINSTON SALEM, NC 27107

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Policyholder/Subscriber ID (SSN or ID#)
10/21/1971	[X] M [ ] F	053681086

16. Plan/Group Number	17. Employer Name
302448	BCD TRAVEL

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above	19. Reserved For Future Use
[ ] Self [ ] Spouse [X] Dependent Child [ ] Other	

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

FRISBIE, FELICITY
4436 GUMTREE RD
WINSTON SALEM, NC 27107

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
11/16/2000	[ ] M [X] F	805030162817

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	66.66
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 66.66

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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) 6/25/2015

42. Months of Treatment 7

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	50. License Number	51. SSN or TIN
1144309410	4151	56-2132966

52. Phone Number	52a. Additional Provider ID
(336) 331-3500	

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI 1790716421

55. License Number

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

56a. Provider Specialty Code 1223X0400X

57. Phone Number	58. Additional Provider ID
(336) 331-3500	903HC

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or go online at adacatalog.org

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

HURT, MELODY L
284 KONNOAK VILLAGE CIRCLE
WINSTON SALEM, NC 27127

13. Date of Birth (MM/DD/CCYY): 11/24/1969

14. Gender: [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#): 242234275

16. Plan/Group Number: 305584

17. Employer Name: NOVANT HEALTH

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

HURT, T'KYAH F
284 KONNOAK VILLAGE CIRCLE
WINSTON SALEM, NC 27127

21. Date of Birth (MM/DD/CCYY): 11/24/1999

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805032162816

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	124.00
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: 124.00

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 7/22/2015

42. Months of Treatment: 15

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) — 11/28/2016 — Date

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

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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

ZUIDEMA, KEVIN A
923 RIDGEGATE DRIVE
LEWISVILLE, NC 27023

13. Date of Birth (MM/DD/CCYY): 01/13/1969

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): 001085584

16. Plan/Group Number: 83010

17. Employer Name: PEPSICO

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

ZUIDEMA, ELENA
923 RIDGEGATE DRIVE
LEWISVILLE, NC 27023

21. Date of Birth (MM/DD/CCYY): 12/03/2003

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805033162815

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	150.00
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: 150.00

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 8/5/2015

42. Months of Treatment: 8

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

©2012 American Dental Association

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

GENUINO, ROY
3800 HEATHER LANE
WINSTON SALEM, NC 27127

13. Date of Birth (MM/DD/CCYY): 02/05/1974

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): 230711646

16. Plan/Group Number: 310649

17. Employer Name: ECOLAB

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

GENUINO, MARIANO
3800 HEATHER LANE
WINSTON SALEM, NC 27127

21. Date of Birth (MM/DD/CCYY): 04/20/2002

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 805041162814

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	150.00
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: 150.00

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 8/4/2015

42. Months of Treatment: 8

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

MATHESON, CHARLES
433 HOLIDAY ST
WINSTON-SALEM, NC 27104

13. Date of Birth (MM/DD/CCYY): 12/04/1952

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): 238769548

16. Plan/Group Number: 305584

17. Employer Name: NOVANT HEALTH

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

MATHESON, BLASE C
433 HOLIDAY ST
WINSTON-SALEM, NC 27104

21. Date of Birth (MM/DD/CCYY): 12/07/2001

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 805043162813

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	150.00
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: 150.00

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: 11/28/2016

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: 11/28/2016

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): 8/12/2015

42. Months of Treatment: 6

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: 11/28/2016

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

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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

MATHESON, CHARLES
433 HOLIDAY ST
WINSTON-SALEM, NC 27104

13. Date of Birth (MM/DD/CCYY): 12/04/1952

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): 238769548

16. Plan/Group Number: 305584

17. Employer Name: NOVANT HEALTH

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

MATHESON, PAUL T
433 HOLIDAY ST
WINSTON-SALEM, NC 27104

21. Date of Birth (MM/DD/CCYY): 12/07/2001

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 805044162812

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	150.00
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: 150.00

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 8/12/2015

42. Months of Treatment: 6

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) — 11/28/2016 — Date

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

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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

MOORE, KEITA
309 SPRINGDALE RD
WALNUT COVE, NC 27052-9549

13. Date of Birth (MM/DD/CCYY): 08/01/1973

14. Gender: [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#): 244434504

16. Plan/Group Number: 305584

17. Employer Name: NOVANT HEALTH

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

MOORE, BETHANY G
309 SPRINGDALE RD
WALNUT COVE, NC 27052-9549

21. Date of Birth (MM/DD/CCYY): 05/28/2003

22. Gender: [ ] M [X] F

23. Patient ID/Account # (Assigned by Dentist): 805055162811

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	150.00
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: 150.00

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 9/10/2015

42. Months of Treatment: 9

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

©2012 American Dental Association

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

SZVETITZ, JOSEPH J
1631 DUPONT ROAD
WINSTON SALEM, NC 27103-4803

13. Date of Birth (MM/DD/CCYY): 08/06/1977

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): 155703580

16. Plan/Group Number: 120731

17. Employer Name: FEDERAL DENTAL

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

SZVETITZ, ANDREW
1631 DUPONT RD
WINSTON SALEM, NC 27103-4803

21. Date of Birth (MM/DD/CCYY): 05/13/2002

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 805017162810

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	140.63
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: 140.63

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 6/24/2015

42. Months of Treatment: 6

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

COBBINS, SHENITA
PO BOX 4266
WINSTON SALEM, NC 27115

13. Date of Birth (MM/DD/CCYY): 01/30/1967

14. Gender: [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#): 237196662

16. Plan/Group Number: 305584

17. Employer Name: NOVANT HEALTH

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

COBBINS, JORDEN M
PO BOX 4266
WINSTON SALEM, NC 27115

21. Date of Birth (MM/DD/CCYY): 12/17/2002

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 800516162809

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	150.00
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: 150.00

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 3/25/2015

42. Months of Treatment: 9

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) — 11/28/2016 — Date

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

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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

POE, LISA I
6390 BISHOP RIDGE LN
RURAL HALL, NC 27045

13. Date of Birth (MM/DD/CCYY): 07/05/1966

14. Gender: [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#): 287586163

16. Plan/Group Number: 0120731

17. Employer Name: FEDERAL DENTAL

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

POE, ADAM M
6390 BISHOP RIDGE LN
RURAL HALL, NC 27045

21. Date of Birth (MM/DD/CCYY): 07/18/2001

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 805026162808

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	140.00
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: 140.00

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: 11/28/2016

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: 11/28/2016

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): 6/10/2015

42. Months of Treatment: 6

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: 11/28/2016

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

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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

GRIFFITH, TRACI
1040 WOODBURY RD
KING, NC 27021

13. Date of Birth (MM/DD/CCYY): 01/14/1983

14. Gender: [ ] M [X] F

15. Policyholder/Subscriber ID (SSN or ID#): 243556400

16. Plan/Group Number: 305584

17. Employer Name: NOVANT HEALTH

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

Griffith, Logan C
1040 Woodbury Rd
King, NC 27021

21. Date of Birth (MM/DD/CCYY): 08/08/2002

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 805027162807

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	150.00
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: 150.00

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 6/11/2015

42. Months of Treatment: 6

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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI: 1790716421

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: 903HC

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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

UNITED CONCORDIA
P O BOX 69421
HARRISBURG, PA 17106

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

MAYER, WILLIAM FRANKLIN
1270 CRESCENT MEADOW DR
CLEMMONS, NC 27012

13. Date of Birth (MM/DD/CCYY): 02/20/1969

14. Gender: [X] M [ ] F

15. Policyholder/Subscriber ID (SSN or ID#): 245114400

16. Plan/Group Number: 254758001

17. Employer Name: SHEETZ

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

MAYER, BRADLEY
1270 CRESCENT MEADOW DR
CLEMMONS, NC 27012

21. Date of Birth (MM/DD/CCYY): 02/18/2002

22. Gender: [X] M [ ] F

23. Patient ID/Account # (Assigned by Dentist): 805161162806

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	128.00
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: 128.00

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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): 9/22/2016

42. Months of Treatment: 10

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) — 11/28/2016 — Date

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

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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

UNITED HEALTHCARE
PO BOX 30567
SALT LAKE CITY, UT 84130

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	8. Policyholder/Subscriber ID (SSN or ID#)
	[ ] M [ ] F	

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

FERRIS, JAMES
1360 BETHESDA CHURCH RD
MADISON, NC 27025

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Policyholder/Subscriber ID (SSN or ID#)
02/11/1981	[X] M [ ] F	243399013

16. Plan/Group Number	17. Employer Name
794802	EVOQUA WATER TECHNOLOGIES LLC

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above	19. Reserved For Future Use
[ ] Self [ ] Spouse [X] Dependent Child [ ] Other	

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

FERRIS, HANNAH
1360 BETHESDA CHURCH RD
MADISON, NC 27025

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
09/04/2002	[ ] M [X] F	805109162805

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	199.58
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 199.58

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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) 4/15/2016

42. Months of Treatment 16

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	50. License Number	51. SSN or TIN
1144309410	4151	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. Martin Slominski — Signed (Treating Dentist) — 11/28/2016 — Date

54. NPI 1790716421

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 903HC

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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

UNITED HEALTHCARE
PO BOX 30567
SALT LAKE CITY, UT 84130

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	8. Policyholder/Subscriber ID (SSN or ID#)
	[ ] M [ ] F	

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

BARNEY, REGINA R
2185 MILLING RD
MOCKSVILLE, NC 27028-7332

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Policyholder/Subscriber ID (SSN or ID#)
01/02/1964	[ ] M [X] F	928486981

16. Plan/Group Number	17. Employer Name
200344	WOMBLE CARLYLE SANDRIDGE & RICE

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above	19. Reserved For Future Use
[ ] Self [ ] Spouse [X] Dependent Child [ ] Other	

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

BARNEY, WILLIAM P
2185 MILLING RD
MOCKSVILLE, NC 27028-7332

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
04/23/2001	[X] M [ ] F	805067162804

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	11/28/2016					D8670			PERIOD ORTHO TX INSTALLMENT	152.16
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 152.16

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 — 11/28/2016 — 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 SIGNATURE ON FILE — Subscriber Signature — 11/28/2016 — Date

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) 10/29/2015

42. Months of Treatment 10

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	50. License Number	51. SSN or TIN
1144309410	4151	56-2132966

52. Phone Number	52a. Additional Provider ID
(336) 331-3500	

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) — 11/28/2016 — Date

54. NPI	55. License Number
1457441420	

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

56a. Provider Specialty Code 1223X0400X

57. Phone Number	58. Additional Provider ID
(336) 331-3500	

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