ADA American Dental Association® Dental Clai	m Fori	m								
HEADER INFORMATION										
Type of Transaction (Mark all applicable boxes)										
X Statement of Actual Services Request for Predetermination/Preauthori	ization									
X EPSDT / Title XIX		┸								
2. Predetermination/Preauthorization Number		_				ER INFORMAT	<u>`</u>			
		12	2. Policyholder	r/Subsc	riber Name (	Last, First, Middle	e Initial, S	uffix), Addre	ess, City, Sta	te, Zip Code
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		վ լ	DEBERR	Y, EL	ISABETH	HOOVER				
3. Company/Plan Name, Address, City, State, Zip Code			353 JONE							
ACS Benefit Service, Inc.		١	WINSTON	N SAL	EM, NC	27104				
P O Box 2050 Winston-Salem, NC 27102-2050			3. Date of Birth	- /8 48 4/5	20/00/04	44 Oandan	45.0	- Carda - Lala - d	0	D (00N ID#)
WillStoff-Galetti, NG 27 102-2000		- 1		`	DD/CCYY)	14. Gender	- 1	-		D (SSN or ID#)
OTHER COVERAGE (Made and State In the Country of th	II- \	_	06/22/197 6. Plan/Group		. [	7. Employer Nan		2600009	9	
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave bl     Use the state of the	iank.)	_	003	Numbe		VAKE FORI		NIVERS	ITY	
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		┰	ATIENT INI	EOPM		WILL TOTA		TIVEITO		
o. Name of Foliographical and Francisco and		$\vdash$				scriber in #12 Ab	2010		19. Reserv	ed For Future
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (S	SSN or ID#)	⊣՝՝	Self		. —	Dependent Child		ther	Use	54 / 51 / 4ta 5
M F	ON OF ID#)	20				Suffix), Address,				
9. Plan/Group Number 10. Patient's Relationship to Person named in #5		-1	DEBERR'			,,,,	,,	, , , , , , , ,		
Self Spouse Dependent	Other		353 JONE	,		TE 217				
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	_	_	WINSTON							
		21	1. Date of Birth	n (MM/E	DD/CCYY)	22. Gender	23. P	atient ID/Aco	count # (Assi	igned by Dentist)
			12/12/200	03		X M	F  805	0361629	904	
RECORD OF SERVICES PROVIDED										
24. Procedure Date of Oral Tooth 27. Tooth Number(s) 28. Tooth			29a. Diag.	29b.		30. D	Description			31. Fee
(MIM/DD/CCYY) Cavity System or Letter(s) Surrace	Code		Pointer	Qty.	555105					
1 11/28/2016	D8670				PERIOD	ORTHO TX	INSTAL	LMENI		199.58
2										
4										
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9										
10										
33. Missing Teeth Information (Place an "X" on each missing tooth.)	34. Diagnosis	Code	List Qualifier		( ICD-9 =	B; ICD-10 = AB )	)	31	a. Other	
	34a. Diagnosis			<u> </u>		С			Fee(s)	
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 (	(Primary diagr	nosis	in " <b>A</b> ")	В		D		32	. Total Fee	199.58
35. Remarks										
AUTHORIZATIONS		ANC	CILLARY CI	LAIM/	TREATME	NT INFORMA	TION			
36. I have been informed of the treatment plan and associated fees. I agree to be responsible charges for dental services and materials not paid by my dental benefit plan, unless pro		38. F		_		=office; 22=O/P Ho		39. Enclosu	res (Y or N)	
law, or the treating dentist or dental practice has a contractual agreement with my plan pr or a portion of such charges. To the extent permitted by law, I consent to your use and d	rohibiting all					rofessional Claims"				
of my protected health information to carry out payment activities in connection with this	claim.	40. Is	s Treatment fo			(0 1 1 11 10)	.			(MM/DD/CCYY)
X SIGNATURE ON FILE 11/28/2016	·	40.1	No (Ski			(Complete 41-42)		/29/2015		+ /MM4/DD/00\0/\
Patient/Guardian Signature Date		42. N	Months of Trea	itment	43. Repla	cement of Prosthe		. Date of Pri	or Placemen	it (MM/DD/CCYY)
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, to the below named dentist or dental entity.	, directly	45 T	7 reatment Res	ulting fr		Yes (Complete	e 44)			
·	,	45. 1		-	ness/injury	☐ Auto a	accident		Other accider	nt
X SIGNATURE ON FILE 11/28/2016 Subscriber Signature Date	<u> </u>	46 F	Date of Accide					<del></del>	Auto Accide	
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity	is not					ATMENT LOC	CATION			The Otale
submitting claim on behalf of the patient or insured/subscriber.)	13 1100					as indicated by				es that require
48. Name, Address, City, State, Zip Code			nultiple visits)				adto di o ii	. progress (	or procedure	oo alaa roquiro
Kenneth M. Sadler, DDS and Associates, PA		V	Dr Debora	ah F I	Novak			11/	28/2016	
201 Charlois Boulevard		^_	Signed (Trea						Date	
Winston-Salem, NC 27103	İ	54. N	<sup>IPI</sup> 14574	4142	20	55	. License	Number		
	İ		ddress, City, S			56 Sr	a. Provide	er ode 1223	3X0400X	
49. NPI 50. License Number 51. SSN or TIN			Charlois Blv							
1144309410 4151 56-2132966			ston-Salem,	NC 27	103					
52 Phone Number (336) 331-3500 S2a Additional Provider ID		57. P	Phone Number (33	36) 33	1-3500	58	B. Addition Provider	al · ID		

A	<b>DA</b> American L	ent	al As	SOCI	ation <sup>®</sup>	<u>Dent</u>	<u>ai Ciai</u>	<u>m</u> For	m								
-	EADER INFORMATION																
1.	Type of Transaction (Mark a	all applic	able bo	xes)													
	X Statement of Actual Se	rvices		Requ	est for Prede	terminatio	n/Preauthori	zation									
	X EPSDT / Title XIX								上								
2.	Predetermination/Preauthor	rization	Number										ER INFORMAT				
$\vdash$									12	2. Policyholde	r/Subsc	riber Name (	Last, First, Middle	Initial, Suf	ffix), Addre	ess, City, Stat	te, Zip Code
-	SURANCE COMPANY					ORMAT	ION		_	DOSS, DA	AVID						
3.	Company/Plan Name, Addr			Zip Cod	le					2812 LOF		ΝE					
ı	ACS Benefit Service	e, Inc	•						-	YADKINV	ILLE,	NC 270	55				
ı	P O Box 2050 Winston-Salem, NO	2710	າວ ວດເ	50										1			
ı	Willston-Salem, NC	<i>J</i>	JZ-ZU\	30						3. Date of Birtl	•	DD/CCYY)	14. Gender	.	-		O (SSN or ID#)
<u></u>									_	04/29/197				LUIU	0001770	0	
-	THER COVERAGE (Mai							ank.)	_	6. Plan/Group	Numbe	I	7. Employer Nam  VAKE FORE		IIV/EDQ	ITV	
<u> </u>	Dental? Medica			•	complete 5-1		ai oniy.)		_				VANE FORE	231 011	IIVENS	111	
J 5.	Name of Policyholder/Subs	criber in	#4 (La	St, First,	ivildale miliai,	Sullix)			- 1	ATIENT IN						10 Pocon	ed For Future
6	Date of Birth (MM/DD/CCY	ν <sub>1</sub> Τ	7. Geno	lor	O Daliauth	ما مام سان دام	anihar ID (C	CN == ID#\	- 18	S. Relationship		_	Dependent Child		ner .	Use	ed For Future
<b> </b> °.	Date of Biltin (WIW/DB/CC)	''	M . Gend	F	8. Policyn	older/Sub	scriber ID (S	SN or ID#)	20				Suffix), Address,				
9	Plan/Group Number				 lationship to I	Person na	med in #5		_	,			oulin), Address,	Oity, Otate	, zip code	•	
•	Tan Group Hamber		Se		Spouse		endent	Other		DOSS, OI		Κ					
11	Other Insurance Company	//Dental			<u> </u>	<u> </u>			_	RURAL H	-	NC 2704!	5				
	,			,	,	, _ ,				,							
l								2	1. Date of Birtl	h (MM/E	DD/CCYY)	22. Gender	23. Pat	tient ID/Ac	count # (Assi	gned by Dentist)	
l									09/14/200	)2		<b>X</b> M _ F	8050	661629	903		
RI	CORD OF SERVICES	PROV	IDED														
Г	24. Procedure Date	25. Area of Oral	26. Tooth	2	7. Tooth Numbe	er(s)	28. Tooth	29. Pro		29a. Diag.	29b.		30 De	escription			31. Fee
L	(MM/DD/CCYY)	Cavity			or Letter(s)		Surface	Cod		Pointer	Qty.						
1	11/5/2015							D8080	)			Compret	nensive Adole	scent Tr	reatmen	ıt	4,950.00
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33	Missing Teeth Information	(Place a	n "Y" o	a each m	nissing tooth		1	4 Diagnosis	Codo	List Qualifier		(ICD 9 -	B; ICD-10 = AB )		31	a. Other	
133		6 7		9 10	11 12 13			4a. Diagnosi			A	(100-9 -	C			Fee(s)	
⊢		7 26	25 2		22 21 20			Primary diag		. ,			c		32	. Total Fee	4,950.00
⊢	. Remarks	., 20						· ·····ai y aias	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	В		<u> </u>				4,930.00
l																	
A	JTHORIZATIONS								ANG	CILLARY C	LAIM/	TREATME	NT INFORMAT	TION			
36	I have been informed of the charges for dental services								38. F	Place of Treatn	nent -	<b>11</b> (e.g. 11	=office; 22=O/P Hos	spital) 39	9. Enclosu	res (Y or N)	
l	law, or the treating dentist of	or dental	practice	has a c	ontractual agr	eement wi	th my plan pr	ohibiting all		(Use "Place	of Service	ce Codes for P	rofessional Claims")				
l	or a portion of such charge of my protected health info								40. l:	s Treatment fo	or Ortho				Date Appli	ance Placed	(MM/DD/CCYY)
lχ	SIGNATURE	ON	FILE			11.	/28/2016			No (Ski	ip 41-42	Yes (	(Complete 41-42)	11.	/5/2015		
l	Patient/Guardian Signature	9				Dat	е		42. N	Months of Trea	atment	I — ' -	cement of Prosthe		Date of Pri	ior Placemen	t (MM/DD/CCYY)
37	I hereby authorize and dire				l benefits oth	erwise pa	yable to me,	directly		24		No	Yes (Complete	44)			
l	to the below named dentis	t or den	tal entit	y.					45. T	reatment Res	_						
ΙX	SIGNATURE	ON	FILE				/28/2016					ness/injury	Auto a	ccident	<u> </u>	Other accider	
<del> -</del>	Subscriber Signature					Dat			_	ate of Accide						Auto Accide	nt State
	LLING DENTIST OR I omitting claim on behalf of t					dentist or o	dental entity	s not	⊢				ATMENT LOC				a that require
48	. Name, Address, City, State	a Zin C	nde							nereby certify nultiple visits)			as indicated by deted.	ate are in	progress (	for procedure	es that require
	enneth M. Sadler, DD			ciates	PΑ				١.,	D. D. L		NII-			441	00/0040	
	1 Charlois Boulevard		, ,5500						X_	Dr Debora					11/2	28/2016 Date	
I <sup>W</sup>	inston-Salem, NC 27	103							54. N	NPI 14574			55.	License N	lumber		
									_	ddress, City,						3X0400X	
49	. NPI	50.	License	Numbe	r	51. SSN	or TIN		ł	Charlois Blv		-	Spe	ecialty Cod	ie IZZC	///U <del>1</del> 00/	
	44309410	41				56-213				ston-Salem,		103					
52	Phone Number (336) 331-3	500			52a. Additio Provide	nal			57. F	Phone Number (33	36) 33	1-3500	58.	Additional Provider I	l ID		

ADA American Dental Association Dental Claim Form	<u>n</u>	
HEADER INFORMATION		
Type of Transaction (Mark all applicable boxes)		
X Statement of Actual Services Request for Predetermination/Preauthorization		
X EPSDT / Title XIX		
2. Predetermination/Preauthorization Number	POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named	
	12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip	p Code
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	ABHULIMEN, MICHAEL E	
3. Company/Plan Name, Address, City, State, Zip Code	3476 SALLY KIRK ROAD	
ACS Benefit Service, Inc.	WINSTON SALEM, NC 27106	
P O Box 2050 Winston-Salem, NC 27102-2050		
Willston-Galem, NG 27 102-2000	13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscriber ID (SS	SN or ID#)
	09/1//1970   🔼	
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)	16. Plan/Group Number 17. Employer Name WFBMC	
4. Dental? Medical? (If both, complete 5-11 for dental only.)	11121112	
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)	PATIENT INFORMATION  18. Relationship to Policyholder/Subscriber in #12 Ahove  19. Reserved Fo	or Euturo
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN or ID#)	18. Relationship to Policyholder/Subscriber in #12 Above 19. Reserved Fo Use	ruture
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN or ID#)	20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	
9. Plan/Group Number 10. Patient's Relationship to Person named in #5		
Self Spouse Dependent Other	ABHULIMEN, ONO 3476 SALLY KIRK ROAD	
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	WINSTON SALEM, NC 27106	
	Time Fort Street, No 27 100	
	21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assigned	by Dentist)
	12/12/2001	
RECORD OF SERVICES PROVIDED		
24. Procedure Date 25. Area 26. 27. Tooth Number(s) 28. Tooth 29. Procedure Date of Oral Tooth 27. Tooth Number(s) 28. Tooth 29. Procedure Date of Oral Tooth 27. Tooth Number(s) 28. Tooth 29. Procedure Date of Oral Tooth 27. Tooth Number(s) 28. Tooth 29. Procedure Date of Oral Date of Oral Date o	dure 29a. Diag. 29b.	31. Fee
(MM/DD/CCYY) Cavity System or Letter(s) Surface Code	Pointer Qty. 30. Description	31. Fee
1 11/28/2016 D8670	PERIOD ORTHO TX INSTALLMENT	228.10
2		
3		
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8		
9		
10 Co. Affective Touth Information (Classes Williams and wide instants)	Code List Qualifier (ICD-9 = B: ICD-10 = AB.) 31a. Other	
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 34a. Diagnosis 0	Fee(s)	
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 (Primary diagn	22 Total Foo	220.40
35. Remarks	osis in "A") B D 32. Total Fee	228.10
AUTHORIZATIONS	ANCILLARY CLAIM/TREATMENT INFORMATION	
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all	38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) 39. Enclosures (Y or N)	
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	(Use "Place of Service Codes for Professional Claims")	
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.	40. Is Treatment for Orthodontics?  41. Date Appliance Placed (MM/	/DD/CCYY)
X SIGNATURE ON FILE 11/28/2016	No (Skip 41-42) X Yes (Complete 41-42) 3/10/2016	
	42. Months of Treatment 43. Replacement of Prosthesis 44. Date of Prior Placement (MM	1/DD/CCYY)
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly	12 No Yes (Complete 44)	
to the below named dentist or dental entity.	45. Treatment Resulting from	
X SIGNATURE ON FILE 11/28/2016	Occupational illness/injury Auto accident Other accident	
Subscriber Signature Date	46. Date of Accident (MM/DD/CCYY) 47. Auto Accident Sta	ate
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)	TREATING DENTIST AND TREATMENT LOCATION INFORMATION	
, , , , , , , , , , , , , , , , , , ,	53. I hereby certify that the procedures as indicated by date are in progress (for procedures tha multiple visits) or have been completed.	at require
48. Name, Address, City, State, Zip Code		
Kenneth M. Sadler, DDS and Associates, PA 201 Charlois Boulevard	X Dr Deborah F Novak 11/28/2016	
Winston-Salem NC 27103	Signed (Treating Dentist)         Date           54. NPI 1457441420         55. License Number	
I -	50 5 11	
	56. Address, City, State, Zip Code Specialty Code 1223X0400X  201 Charlois Blvd	
	Winston-Salem, NC 27103	
52. Phone (226) 224 2500   52a. Additional	57. Phone Number (336) 331-3500   58. Additional Provider ID	
Number (336) 331-3300 Provider ID	Number (336) 331-3300 Provider ID	

A	<b>DA</b> American L	ent	al As	SOCI	ation®	Dent	ai Ciai	m For	m								
Н	EADER INFORMATION	1															
1.	Type of Transaction (Mark a	II applic	able bo	xes)													
	X Statement of Actual Ser	vices		Requ	est for Prede	terminatio	n/Preauthori	zation									
L	X EPSDT / Title XIX																
2.	Predetermination/Preauthor	ization l	Number						- ⊢-				ER INFORMAT	<u>`</u>			
L									12	2. Policyholde	r/Subsc	riber Name (	Last, First, Middle	Initial,	Suffix), Addre	ess, City, Sta	te, Zip Code
-	ISURANCE COMPANY					ORMAT	ION		<b>—</b>   1	HALL, JO	NATH	HAN B					
3.	Company/Plan Name, Addr	ess, City	y, State,	Zip Cod	le					,			E COURT				
l	AMERITAS P O BOX 82520									LEWISVIL	LE, 1	NC 27023	3				
l	LINCOLN, NE 6850	)1							1	3. Date of Birtl	- /NANA/F	ND/CCV/V	14 Candar	15	Delieubelden	/Cubaaribar II	D (00N or ID#)
l	EINOOLIN, INE OOO	, ,									,	DD/CCTT)	14. Gender  X M F	.	-		D (SSN or ID#)
F	THER COVERACE (Man	de ammilia	-4-1-6-			E 44 15 m			_	03/01/197 6. Plan/Group		- 1	7. Employer Nam	24	3136859	1	
-	THER COVERAGE (Mar Dental? Medica				complete 5-1			arik.)	_	301224	Numbe	I	ORSYTH C		ITY		
H	Name of Policyholder/Subse			•			ai Only.)		-	ATIENT IN	EODM		OROTHIO				
"	realite of Folloyfloide/Founds	JIIDCI III	# 4 (Lu	ot, 1 110t,	madic inidal,	(Cullix)			$\vdash$				scriber in #12 Ab	101/0		19 Reserv	ed For Future
6.	Date of Birth (MM/DD/CCY)	<u>()</u>	7. Geno	der	8 Policyh	older/Sub	scriber ID (S	SN or ID#)	⊢"	Self		_	Dependent Child		Other	Use	54 / 51 / 4ta 5
		·′	М	F	O. I Olicyli	older/oub	scriber ib (o	514 OF 1D#)	20				Suffix), Address,			 e	
9.	Plan/Group Number	$\overline{}$		ent's Re	l lationship to l	Person na	med in #5		_	HALL, MA			,,	,,	,		
			Se		Spouse		endent	Other		,			E COURT				
11	. Other Insurance Company	/Dental	Benefit	Plan Na	me, Address,	City, State	e, Zip Code		_	LEWISVIL							
l								21	1. Date of Birtl	n (MM/E	DD/CCYY)	22. Gender	- 1	Patient ID/Ac	count # (Assi	igned by Dentist)	
L									05/02/200	)2		M X F	808	5105162	901		
R	ECORD OF SERVICES	PROV	IDED														
Г	24. Procedure Date	25. Area of Oral		2	7. Tooth Number	er(s)	28. Tooth	29. Pro		29a. Diag.	29b.		30. D	escriptior	n		31. Fee
Ŀ	(MM/DD/CCYY)	Cavity			or Letter(s)		Surface	Cod		Pointer	Qty.	555105					
1	11/28/2016							D867	)			PERIOD	ORTHO TX	INSTA	ALLMENT		100.00
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33	. Missing Teeth Information	Place a	n "X" or	n each m	nissina tooth.)	)	3	4. Diagnosis	Code	List Qualifier		( ICD-9 =	B; ICD-10 = AB )		31	1a. Other	
Н		3 7		9 10	11 12 13			4a. Diagnos			<u>ш</u>	(	С			Fee(s)	
L	32 31 30 29 28 2	7 26	25 2	4 23	22 21 20	0 19 1	8 17 (	Primary diag	gnosis	in " <b>A</b> ")	В		 D		32	2. Total Fee	100.00
35	. Remarks																
l																	
A	UTHORIZATIONS								ANG	CILLARY C	LAIM/	TREATME	NT INFORMAT	ΓΙΟΝ			
36	. I have been informed of the charges for dental services								38. F		_		=office; 22=O/P Ho		39. Enclosu	ures (Y or N)	
l	law, or the treating dentist of	r dental	practice	has a c	ontractual agr	eement wi	th my plan pr	ohibiting all		(Use "Place	of Servi	ce Codes for P	rofessional Claims")	)			
l	or a portion of such charge of my protected health info	mation	to carry	out payr	nent activities	in connec	tion with this	claim.	40. Is	s Treatment fo				- 1	11. Date Appl	liance Placed	(MM/DD/CCYY)
Ιx	SIGNATURE		FILE				/28/2016			No (Ski			(Complete 41-42)		3/29/2016		
l	Patient/Guardian Signature	,				Dat	е		42. N	Months of Trea	tment	I — ' -	cement of Prosthe	- 1	14. Date of Pr	rior Placemen	it (MM/DD/CCYY)
37	. I hereby authorize and dire				al benefits oth	erwise pa	yable to me,	directly	<u>                                     </u>	15	u: -	No	Yes (Complete	9 44)			
l	to the below named dentis	t or aen	tai entit	у.					45. 1	reatment Res	-		Ato .o			04	-4
Ιx		ON	FILE				/28/2016					ness/injury	Auto a	ccident	<del></del>	Other accider	
Ŀ	Subscriber Signature					Dat			_	ate of Accide						. Auto Accide	ent State
	ILLING DENTIST OR DE bmitting claim on behalf of to					dentist or o	dental entity	s not	⊢				ATMENT LOC				as that require
48	. Name, Address, City, State	Zin Co	nde							nereby certify nultiple visits)			as indicated by deted.	iate are	in progress	(for procedure	es mai require
	enneth M. Sadler, DD			riates	ΡΔ											10010010	
	01 Charlois Boulevard		A3300	Jiaies,					X_	Dr Debora					11/	/28/2016 Date	
I۷	/inston-Salem, NC 27	103							54. N	NPI 14574			55.	. License	e Number		
									_	ddress, City,						3X0400X	
49	. NPI	50.	License	Numbe	r	51. SSN	or TIN		ł	Charlois Blv		-	[ Sp	ecialty (	Joue IZZ	U/\U <del>+</del> UU/\	
	144309410	41		_		56-213				ston-Salem,		103					
52	Phone Number (336) 331-35	500			52a. Additio Provide	nal			57. F	Phone Number (33	36) 33	1-3500	58.	. Additio Provide	nal		

Æ	<b>ADA</b> American L	Denta	al As:	socia	tion®	Dent	al Cla	iim F	orm								
F	HEADER INFORMATION	N P															
_ [1	I. Type of Transaction (Mark a	all applic	able box	xes)													
-	X Statement of Actual Se	rvices		Reques	st for Prede	terminatio	n/Preautho	rization									
-	X EPSDT / Title XIX																
2	2. Predetermination/Preautho	rization I	Number							POLICYHOL	DER/S	UBSCRIB	ER INFORM	ATION	(For Insuran	ce Company N	lamed in #3)
-									l	12. Policyholder	r/Subsc	riber Name (	Last, First, Mid	ldle Initi	ial, Suffix), Add	dress, City, Sta	te, Zip Code
h	NSURANCE COMPANY	/DENT	AL BE	NEFIT I	PLAN INF	ORMAT	ION		$\neg$								
- 1-	3. Company/Plan Name, Addr					- Citilla			-	CHERRY,							
- [	AMERITAS		,,,	_,						652 BARF							
-	P O BOX 82520									CLEMMO	NS, I	NC 27012	2				
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Ι,	THER COVERAGE (Ma	rlı annlia	abla bay	, and som	nlata itama	E 11 If no	one leeve	hlank \	$\overline{}$	16. Plan/Group		ar I	17. Employer N		23023400	<u> </u>	
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- ⊢							ai Oiliy.)		-				01101111	120	,, , , , , , , , , , , , , , , , , , ,		
٦			#4 (Las	st, First, ivi	liddle miliai,	Sullix)				PATIENT IN						10 Decem	ed For Future
B 6			7.0.1	· · ·	1				_	18. Relationship		. –	7			Use Use	ed For Future
٦ [	,	· 1			1		scriber ID (	(SSN or I	·	X Self		pouse	Dependent C		Other		
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ا	•							Other		CHERRY,			_				
$\perp$		15				<u> </u>				652 BARF							
	11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code DELTAL DENTAL OF MI PO BOX 9085 FARMINGTON HILLS, MI 48333  RECORD OF SERVICES PROVIDED  24. Procedure Date   25. Area   26.   27. Tooth Number(s)   28. Tooth								CLEMMO	NS, N	NC 2/012	_					
-									-				T	- 1.			
Т	11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code									21. Date of Birth	-	DD/CCYY)	22. Gender	_		-	igned by Dentist)
L				333						11/11/195	9				30511516	2900	
<u> </u>	RECORD OF SERVICES																
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Ь	, ,	Cavity	System		Or Ection(3)		Carract			Tollitor	Gty.	DEDIOR	ODTUG	V INIO	TALL NACAL	т	140.00
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3	33. Missing Teeth Information	(Place a	n "X" on	each mis	sing tooth.)			34. Diag	nosis Cod	de List Qualifier		( ICD-9 =	B; ICD-10 = A	В)	:	31a. Other Fee(s)	
L	1 2 3 4 5	6 7	8 9	10 1	11 12 1	3 14 1	5 16	34a. Dia	gnosis Co	ode(s)	Α		c				
L	32 31 30 29 28 2	27 26	25 24	4 23 2	22 21 20	) 19 1	8 17	(Primary	/ diagnosi	is in " <b>A</b> ")	В		D		;	32. Total Fee	148.60
g 3	85. Remarks																
L																	
4	AUTHORIZATIONS								AN	ICILLARY CI	LAIM/	TREATME	NT INFORM	IATIO	N		
3	<ol> <li>I have been informed of the charges for dental services</li> </ol>									. Place of Treatm	nent [	11 (e.g. 11	1=office; 22=O/P	Hospital	1) 39. Enclo	sures (Y or N)	
-	law, or the treating dentist of	or dental	practice	has a con	ntráctual agr	eement wi	th my plan	prohibiting	g all	(Use "Place	of Servi	ce Codes for F	Professional Clair	ns")			
-	or a portion of such charge of my protected health info								e 40.	. Is Treatment fo	r Ortho	dontics?			41. Date Ap	pliance Placed	(MM/DD/CCYY)
Ь				. ,			/28/201			No (Ski	p 41-42	2) X Yes	(Complete 41-	42)	4/26/201	6	
ľ	Patient/Guardian Signature					Dat	е		42.	Months of Trea	tment	43. Repla	cement of Pros	sthesis	44. Date of I	Prior Placemen	nt (MM/DD/CCYY)
3	37. I hereby authorize and dire	ect navn	ent of th	ne dental	henefits oth	erwise na	vable to me	e directly	_	6		No	Yes (Comp	lete 44)			
٦	to the below named dentis				benenis ou	ci wise pa	yable to m	c, all colly		. Treatment Res	ulting fr	rom					
I,	x SIGNATURE	- ON I	FILE			11	/28/201	6		Occupa	tional ill	lness/injury	Aut	o accid	ent	Other accider	nt
ľ	Subscriber Signature		166			Dat			— <del> </del> 46.	. Date of Accide	nt (MM/	/DD/CCYY)				7. Auto Accide	ent State
Ī	BILLING DENTIST OR I	DENTA	L ENTI	ITY (Lea	ve blank if	dentist or	dental entit	y is not	TR	REATING DEI	NTIST	AND TRE	ATMENT L	OCATI	ION INFOR	MATION	
s	submitting claim on behalf of t	he patie	nt or insu	ured/subs	scriber.)			•	53.	I hereby certify	that the	e procedures	s as indicated b	y date a	are in progress	(for procedure	es that require
4	18. Name, Address, City, State	e, Zip Co	ode							multiple visits)	or have	been compl	leted.				-
H	Kenneth M. Sadler, DD	S and	Assoc	iates, P	'A					Dr. Martin	مای	mineki			11	1/28/2016	
	201 Charlois Boulevard	1								Signed (Trea					1	Date	
1	Winston-Salem, NC 27	103							54.	NPI 17907			I	55. Lice	ense Number		
										. Address, City, S				56a. Pr	ovider 12	23X0400X	
	19. NPI	50	License	Number		51. SSN	or TIN			1 Charlois Blv			L	opecial	ny Code IZZ	-UAUUA	
	1144309410	415				56-213				nston-Salem,		103					
	52. Phone (226) 221 2				52a. Additio	nal			57.	Phone (33	36) 33	1-3500		58. Add	ditional 903	BHC	
- 1	Number (336) 331-3				Provide	er ID				Number (33	.0,00	. 5555		Pro	vider ID 300	, IU	

ADA American Dental Association® Dental Cla	aim For	m							
HEADER INFORMATION									
1. Type of Transaction (Mark all applicable boxes)									
X Statement of Actual Services Request for Predetermination/Preauth	orization								
X EPSDT / Title XIX		L							
2. Predetermination/Preauthorization Number		P	OLICYHOL	DER/S	UBSCRIBI	ER INFORMAT	ION (For Insura	nce Company N	lamed in #3)
		12	2. Policyholder	/Subsc	riber Name (I	_ast, First, Middle	Initial, Suffix), A	ddress, City, Sta	te, Zip Code
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		$\Box$ ,	CORNE, J	אטטו	/ \//AYNE	:			
3. Company/Plan Name, Address, City, State, Zip Code			,			RELAND RD			
AMERITAS			KING, NC		_				
P O BOX 82520		$\perp$				<b>T</b>			
LINCOLN, NE 68501			<ol><li>Date of Birth</li></ol>	•	DD/CCYY)	14. Gender		der/Subscriber II	D (SSN or ID#)
		_	05/02/197			X M F	2426969	04	
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave	blank.)	_	6. Plan/Group	Numbe	I	7. Employer Name		LINILIT OOF	<b>1</b> D
4. Dental? Medical? (If both, complete 5-11 for dental only.)		-	350473			KRISPY KRE	ME DOUG	HNUT COF	KP
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		-	ATIENT INF					40 D	. d 5 5 . t
C Data of Dieth (MM/DD/CO)(A)		—  <sup>18</sup>	_ `		_	scriber in #12 Abo		Use	ed For Future
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID	(SSN or ID#)		Self			Dependent Child	Other	\	
9. Plan/Group Number 10. Patient's Relationship to Person named in #5	:	_				Suffix), Address, (	Jity, State, Zip C	ode	
Self Spouse Dependent	Other		CORNE, N						
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Cod		_	KING, NC			ELAND RD			
The date incurate company behalf belief that that is, readed, only, state, 2p con			14110, 140	2102	- '				
		21	1. Date of Birth	n (MM/E	DD/CCYY)	22. Gender	23. Patient ID	)/Account # (Assi	igned by Dentist)
			01/05/200	)4		M X F	8050561	62899	
RECORD OF SERVICES PROVIDED									
24 Procedure Date 25. Area 26. 27 Tooth Number(s) 28 To	oth 29. Proc	edure	29a. Diag.	29b.					
(MM/DD/CCYY) of Oral Cavity System or Letter(s) Surface			Pointer	Qty.		30. De	scription		31. Fee
1 11/28/2016	D8670	)			PERIOD	ORTHO TX I	NSTALLMEI	NT	83.34
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33. Missing Teeth Information (Place an "X" on each missing tooth.)	34. Diagnosis				( ICD-9 =	B; ICD-10 = AB )		31a. Other Fee(s)	
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	34a. Diagnosi		. ,	Α		C		` '	
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17	(Primary diag	nosis i	in " <b>A</b> ")	В		D		32. Total Fee	83.34
35. Remarks									
AUTHORIZATIONS		ANG	CILL ABV CI	AIRE	TDEATME	NT INFORMAT	ION		
36. I have been informed of the treatment plan and associated fees. I agree to be respon	sible for all					=office; 22=O/P Hos		losures (Y or N)	
charges for dental services and materials not paid by my dental benefit plan, unless plaw, or the treating dentist or dental practice has a contractual agreement with my plan	rohibited by	00.1		_		rofessional Claims")	pital)		
or a portion of such charges. To the extent permitted by law, I consent to your use and	d disclosure	40. Is	s Treatment fo	r Ortho	dontics?		41. Date A	oppliance Placed	(MM/DD/CCYY)
of my protected health information to carry out payment activities in connection with the X SIGNATURE ON FILE 11/28/201			No (Ski			(Complete 41-42)	9/21/20		(
X SIGNATURE ON FILE 11/28/201 Patient/Guardian Signature Date		42. N	Months of Trea			cement of Prosthes			it (MM/DD/CCYY)
	a dinasth.		9		No	Yes (Complete			,
37. I hereby authorize and direct payment of the dental benefits otherwise payable to m to the below named dentist or dental entity.	ne, airectly	45. T	Freatment Resi	ulting fr	om				
X SIGNATURE ON FILE 11/28/20	16		Occupat	tional ill	ness/injury	Auto ad	cident	Other accider	nt
Subscriber Signature Date		46. D	Date of Accider	nt (MM/	DD/CCYY)			47. Auto Accide	ent State
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental enti	ity is not	TRE	EATING DE	NTIST	AND TRE	ATMENT LOCA	ATION INFO	RMATION	
submitting claim on behalf of the patient or insured/subscriber.)						as indicated by da	ate are in progre	ss (for procedure	es that require
48. Name, Address, City, State, Zip Code		n	nultiple visits)	or have	been comple	eted.			
Kenneth M. Sadler, DDS and Associates, PA		Х	Dr. Martin	Slo	minski			11/28/2016	
201 Charlois Boulevard Winston-Salem, NC 27103			Signed (Trea					Date	
Williatori-Galerii, NG 27 100		54. N	NPI 17907	1642	21		License Numbe		
		56. A	Address, City, S	State, Z	ip Code	56a Spe	. Provider cialty Code 12	223X0400X	
49. NPI 50. License Number 51. SSN or TIN			Charlois Blvo		103				
1144309410 4151 56-2132966			ston-Salem, I			Lea	Λ alalitic!		
52. Phone Number (336) 331-3500 52a. Additional Provider ID		57. P N	Phone Number (33	36) 33	1-3500	58.	Additional Provider ID 90	3HC	

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											12. Policynoider	r/Subsc	riber Name (	Last, First	ivildale in	itial, Suffix), Add	iress, City, Sta	ite, Zip Code
- 1	INSURANCE CO 3. Company/Plan Na						ORMAI	ION			EAST, GA	ARY L	_					
l`	AMERITAS	ame, Addre	ess, City	y, State,	Zip Code						112 MEA							
	P O BOX 82	2520									DANBUR'	Y, NC	27016					
	LINCOLN, N		)1							-	13. Date of Birth	n (MM/E	OD/CCYY)	14. Gen	der	15. Policyholde	er/Subscriber I	D (SSN or ID#)
											07/24/197	71	,	X	F	24327355	2	
ŀ	OTHER COVER	AGE (Mar	k applic	able box	x and com	plete items	5-11. If n	one, leave	blank.)		16. Plan/Group		er '	17. Employ				
-						-			,		301224		ı	FORSY	TH CC	UNTY GO	VERNMEN	NT
	5. Name of Policyho	lder/Subso	criber in	#4 (Las	st, First, M	liddle Initial,	Suffix)			Ī	PATIENT INI	FORM	ATION					
	BECKY M E	AST								T	18. Relationship	to Poli	icyholder/Sul	oscriber in	#12 Abov	e		ed For Future
<b>-</b> ₫	6. Date of Birth (MM	/DD/CCY	Y)	7. Gend	ler	8. Policyh	older/Sub	scriber ID (	(SSN or I	D#)	Self	Sp	pouse X	Depende	nt Child	Other	Use	
L	07/14/1975			M	χF	015957	635			2	20. Name (Last,	, First, I	Middle Initial,	Suffix), Ad	ldress, Ci	ty, State, Zip Co	de	
9	•	er						_	$\neg$		EAST, ISA	AIAH						
	11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code Assurant P O Box 2940										112 MEA							
	11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code Assurant										DANBUR'	Y, NC	27016					
	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)  07/14/1975  9. Plan/Group Number  5476379  10. Patient's Relationship to Person named in #5  Self Spouse X Dependent Ott  Assurant  P O Box 2940  Clinton, IA 52733  RECORD OF SERVICES PROVIDED  24. Procedure Date (MM/DD/CCYY)  11. 11/28/2016  24. Procedure Date (MM/DD/CCYY)  15. Area of Oral Cavity System  16. Date of Birth (MM/DD/CCYY)  26. Tooth Cavity System  27. Tooth Number(s) or Letter(s)  28. Tooth Surface  27. Tooth Number(s) or Letter(s)  3 4 5 6 7 7 8 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9										04.0.4.60:11	(2.42.47	20.00.00	Tan 0		00 0 11 11011		
											21. Date of Birth 10/11/200		DD/CCYY)	22. Gend		23. Patient ID/A 805045162		igned by Dentist)
											10/11/200				'	00304310	2090	
-	Solution   Solution										T		Ι					
											e 29a. Diag. Pointer	29b. Qty.			30. Desc	ription		31. Fee
	1 11/28/2016	Cystem					D	8670			PERIOD	ORTH	O TX IN	STALLMEN <sup>1</sup>	T	100.00		
	24. Procedure Date (MM/DD/CCYY)         25. Area of Oral Cavity         26. Tooth System         27. Tooth Number(s) or Letter(s)         28. Tooth Surface           11/28/2016         11/28/2016         27. Tooth Number(s) or Letter(s)         28. Tooth System																	
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_pg		9 28 2	7 26	25 2	4 23 2	22 21 20	) 19 1	18 17	(Primar	y diagnosis	s in "A")	В					52. IOIAI FEE	100.00
`ا `	55. Remarks																	
<u> </u>	AUTHORIZATIO	NS								IΔN	ICILLARY CI	ΔIM/	TREATME	NT INFO	RMATI	ON		
- ⊢	36. I have been infor		treatme	ent plan	and asso	ciated fees.	I agree to	be respons	sible for a	-	Place of Treatm		11 (e.g. 11				sures (Y or N)	
	charges for denta law, or the treating										(Use "Place	_	ce Codes for P					
	or a portion of su of my protected h	ch charge:	s. To the	extent p	permitted	by law, I cor	sent to yo	our use and	disclosu	<u> </u>	Is Treatment fo	r Ortho	dontics?			41. Date Ap	pliance Placed	(MM/DD/CCYY)
		ATURE			out paymit	one douvidoo		/28/201			No (Ski	ip 41-42	2) X Yes	(Complete	41-42)	8/11/201	5	
ľ	Patient/Guardian						Dat	te		42.	Months of Trea	tment	43. Repla	cement of	Prosthesis	44. Date of I	Prior Placemer	nt (MM/DD/CCYY)
3	37. I hereby authoriz	ze and dire	ect payn	nent of th	he dental	benefits oth	erwise pa	yable to m	e, directly	=	11		No	Yes (Co	omplete 4	4)		
	to the below nan	ned dentis	t or den	tal entity	/.					45.	Treatment Res	ulting fr	rom					
		ATURE	ON	FILE				/28/201	16	_ L	Occupa	tional ill	lness/injury		Auto acc	ident	Other accide	nt
ŀ	Subscriber Signa						Dat	-		_	Date of Accide						7. Auto Accide	ent State
	BILLING DENTI submitting claim on						dentist or	dental entit	ty is not							TION INFOR		
⊢										53.	I hereby certify multiple visits)				ed by date	e are in progress	s (for procedur	es that require
- 1	48. Name, Address, Kenneth M. Sad	-			iatas P	Δ												
	201 Charlois Bo	,		A5500	Jales, F	^				X	Or Debora Signed (Trea					11	1/28/2016 Date	
	Winston-Salem	, NC 27	103							54	NPI 14574				55.11	cense Number	Date	
											Address, City, S					Provider alty Code 122	23.0100.	,
	49. NPI		50.	License	Number		51. SSN	or TIN			1 Charlois Blv				Spec	aity Code 122	-JAU400A	<b>\</b>
	1144309410		415				56-213				nston-Salem,		103					
	52. Phone Number (336	) 331-35	500		:	52a. Additio Provide	nal er ID			57.	Phone Number (33	36) 33	1-3500		58. A	dditional rovider ID		

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- 1-	_	EADER INFORMATION							$\Box$								
	1.	Type of Transaction (Mark a		able bo	_												
	Į	X Statement of Actual Ser	vices	L	Request fo	r Predetermination	n/Preauth	orization									
L	L	X EPSDT / Title XIX															
- [	2.	Predetermination/Preauthori	ization l	Number					- ⊢	POLICYHOL					·		
Ļ									-1	12. Policyholder	/Subsc	riber Name (	Last, First, Mide	dle Initia	al, Suffix), Add	dress, City, Sta	ite, Zip Code
- 1-						N INFORMAT	ION		_	CRAVER,	JILL						
- 1	3.	• •	ess, Cit	y, State,	Zip Code					203 NIFO	NG F	RD					
										CLEMMO	NS, I	NC 27012	2				
			)1						-	13. Date of Birth	(NANA/I	DD/CCVV)	14. Gender	1	5 Policyholde	ar/Subscriber II	D (SSN or ID#)
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H		THER COVERAGE (Mari	k applia	abla ba	v and complet	o itomo 5 11 If n	ono logyo	blank )	$\dashv$	16. Plan/Group		ar .	17. Employer Na		24013099	0	
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- 1-	_						,.,		٦,	PATIENT IN	FORM						
		KEITH WILKE		`		, ,			- 1	18. Relationship			bscriber in #12	Above		19. Reserv	ed For Future
- g	6.	Date of Birth (MM/DD/CCYY	()	7. Gend	ler 8.	Policyholder/Sub	scriber ID	(SSN or ID#)	$\dashv$	Self		_	Dependent Ch		Other	Use	
	•	10/03/1973		$\mathbf{X}$ M	☐ F 10	1774646			2	20. Name (Last,	First, I	Middle Initial,	Suffix), Addres	s, City,	State, Zip Co	de	
	9.	Plan/Group Number		10. Pati			_			CRAVER,	COL	TON R					
	6. Date of Birth (MM/DD/CCYY) 10/03/1973									203 NIFO	NG R	RD					
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										21. Date of Birth 02/25/200		DD/CCYY)	22. Gender	, I	23. Patient ID// 30051416:	-	igned by Dentist)
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H	K						T										
		24. Procedure Date	of Oral	Tooth						29a. Diag. Pointer	29b. Qty.		30.	Descrip	otion		31. Fee
ı	1	11/28/2016	- Curry	,,,,,,,,,,,,				D867	0			PERIOD	ORTHO T	K INS	TALLMEN	T	83.34
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╌	_							(Primary dia		. ,	Α		c			32. Total Fee	83.34
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Ţ	Αl	UTHORIZATIONS							AN	ICILLARY CI	LAIM/	TREATME	NT INFORM	ATION	N		
Ī	36								38.	Place of Treatm	nent [	11 (e.g. 11	1=office; 22=O/P I	Hospital)	) 39. Enclo	sures (Y or N)	
		law, or the treating dentist or	r dental	practice	has a contrac	tual agreement w	ith my plan	prohibiting all		(Use "Place	of Servi	ce Codes for F	Professional Claim	s")			
									40.	Is Treatment fo					41. Date Ap	pliance Placed	I (MM/DD/CCYY)
	Χ			FILE				16		No (Ski			(Complete 41-4		3/17/201		
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		bmitting claim on behalf of th						.,	-	I hereby certify							es that require
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		enneth M. Sadler, DDS		Assoc	ciates, PA				<sub>x</sub>	Dr. Martin	. Slo	minski			11	1/28/2016	
		01 Charlois Boulevard /inston-Salem, NC 271							Ľ	Signed (Trea						Date	
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		12. Poli	cyholder/	/Subsci	riber Name (	Last, First, Middl	e Initial, Suff	ix), Address	, City, Stat	e, Zip Code
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4. Dental? Medical? (If both, complete 5-11 for dental only.	)	350	369		1	NASH-ROC	KY MOU	INT SCH	HOOLS	
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MF		20. Nam	ne (Last,	First, N	Middle Initial,	Suffix), Address	, City, State,	Zip Code		
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36. I have been informed of the treatment plan and associated fees. I agree to be response	ponsible for all	38. Place of				=office; 22=O/P H		. Enclosures	(Y or N)	
charges for dental services and materials not paid by my dental benefit plan, unle	ss prohibited by				· ·	rofessional Claims	· ′		, (, o, , , ,	
law, or the treating dentist or dental practice has a contractual agreement with my part or a portion of such charges. To the extent permitted by law, I consent to your use	and disclosure	40. Is Trea	tment for	Ortho	dontics?		41 0	)ate Annlian	ce Placed	(MM/DD/CCYY)
of my protected health information to carry out payment activities in connection with SIGNATURE ON FILE 11/28/2			No (Skip			(Complete 41-42		/2016	cc i ideca	(IVIIVII/DB/0011)
X SIGNATURE ON FILE 11/28/2 Patient/Guardian Signature Date	2010	42. Months				cement of Prosth	0,0,		Placement	(MM/DD/CCYY)
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x SIGNATURE ON FILE 11/28/2	2016			-	ness/injury	Auto	accident	Oth	er acciden	t
X SIGNATURE ON FILE 11/28/2 Subscriber Signature Date		46. Date of						<del></del>	uto Accide	
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental	entity is not					ATMENT LO	CATION IN			
submitting claim on behalf of the patient or insured/subscriber.)	entity is not					as indicated by				s that require
48. Name, Address, City, State, Zip Code					been comple		a. o iii p	. 25. 000 (101	,	roquito
Kenneth M. Sadler, DDS and Associates, PA		V Dr 1	Mortin	QI <sub>0</sub>	mineki			11/20	3/2016	
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<sup>물</sup> 6	6. Date of Birth (MM/DD/CCY)	Y)	7. Gend	ler 8. Pol	icyholder/Sub	scriber ID	(SSN or ID#)		Self	S	pouse X	Dependent C	nild [	Other	Use	
	09/25/1973		M		-		,	2	20. Name (Last	, First, I	Middle Initial,	Suffix), Addres	ss, City	, State, Zip Co	de	
9	. Plan/Group Number		10. Pati	ent's Relationship	to Person na	med in #5		$\neg$	JACOBS,	MAK	AYLA					
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	Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)  RENEE JACOBS  Date of Birth (MM/DD/CCYY)  09/25/1973  Plan/Group Number 460824  1. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code  GUARDIAN P O BOX 2459 SPOKANE, WA 99210  RECORD OF SERVICES PROVIDED  24. Procedure Date (MM/DD/CCYY)  11/28/2016  3. 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 34a 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 (Pr. Semarks  SUTHORIZATIONS  6. I have been informed of the treatment plan and associated fees. I agree to be responsible charges for dental services and materials not paid by my dental benefit plan, unless prohiblaw, or the treating dentist or dental practice has a contractual agreement with my plan prob or a portion of such charges. To the extent permitted by law, I consent to your use and disc of my protected health information or carry out payment activities in connection with this cit.  SIGNATURE ON FILE  11/28/2016  7. I hereby authorize and direct payment of the dental benefits otherwise payable to me, dit to the below named dentist or dental entity.								21. Date of Birth		DD/CCYY)	22. Gender	_ I		-	igned by Dentist)
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ľ	charges for dental services	and ma	terials n	ot paid by my den	tal benefit pla	n, unless p	rohibited by	38.	Place of Treatm (Use "Place	_		1=office; 22=O/P Professional Clain		ii) 39. Encio	sures (Y or N)	
	or a portion of such charge	s. To the	extent	permitted by law,	consent to yo	our use and	disclosure	40	Is Treatment fo				,	41 Date An	nliance Placed	I (MM/DD/CCYY)
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Ľ	Subscriber Signature	- 011			Da			46.	Date of Accide	nt (MM	/DD/CCYY)				7. Auto Accide	ent State
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s	ubmitting claim on behalf of t	he patie	nt or ins	sured/subscriber.)					I hereby certify multiple visits)				y date	are in progress	s (for procedur	es that require
- 1	8. Name, Address, City, State							'	multiple visits)	OI Have	e been compi	leteu.				
	Kenneth M. Sadler, DD 201 Charlois Boulevard		Assoc	ciates, PA				X	Dr. Martin					1′	1/28/2016	
	Winston-Salem, NC 27							54	Signed (Trea				EE Lie	once Number	Date	
								-	NPI 17907 Address, City, S					ense Number	22.70.402.7	
	9. NPI	50	License	Number	51. SSN	or TIN		4	Address, City, 8		-ib code	L	Specia	rovider Ity Code 122	23XU4UUX	
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- 1	2. Phone (226) 224 2			52a. Ad	ditional			57.	Phone (33	36) 33	1-3500		58. Add	ditional ovider ID 903	BHC	
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Some and Policy / 1997   199			1	12. Policyholder	/Subsc	riber Name (	Last, First, Midd	le Initial, Suf	ffix), Address, City, St	ate, Zip Code
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Self   Spouse   Department   Other   391 ACT DRIVE   WINSTON SALEM, NC 27107   21. Date of the Insulance Company/Dental Benefit Plan Name, Address, City, State, Zap Code   WINSTON SALEM, NC 27107   22. Gender   12.712/2005   M   X   F   80.5101162894			2	20. Name (Last,	First, N	Middle Initial,	Suffix), Address	, City, State,	e, Zip Code	
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24   Procedure Date   St. Area   36.   St. Area   16.   Code   Stylene   11/28/2016   Code   Protect   11/28/2016   Code   Protect   11/28/2016   Code   Protect   Code   Prot				12/12/200	)5		M X	F 8051	101162894	
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3. 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 34 a. Diagnosis Code(s) A C C Fee(s)  32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17  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, to the treatment plan and associated fees. I agree to be responsible for all cargosity of the dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treatment plan and associated fees. I agree to be responsible for all cargosity of the dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treatment plan and associated fees. I agree to be responsible for all cargosity of the dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treatment plan and associated fees. I agree to be responsible for all cargosity of the dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treatment plan and associated fees. I agree to be responsible for all cargosity of the dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treatment plan and associated fees. I agree to be responsible for all cargosity or the treatment plan and associated fees. I agree to be responsible for all cargosity or the treatment plan and associated fees. I agree to be responsible for all cargosity or the treatment plan and associated fees. I agree to be responsible for all cargosity or the treatment plan and associated fees. I agree to be responsible for all cargosity or the treatment plan and associated fees. I agree to be responsible for the plan prohibitization or th	9									
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32 31 30 29 28 27 26 25 24 23 32 21 20 19 18 17   (Primary diagnosis in "A")   B   D   32. Total Fee   71.44	33. Missing Teeth Information (Place an "X" on each missing tooth.)	34. Diagno	sis Code	e List Qualifier		( ICD-9 =	B; ICD-10 = AB	)		
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, it 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  X SIGNATURE ON FILE  11/28/2016  Date  11/28/2016  Date  11/28/2016  BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  45. Treatment Resulting from  Occupational illness/finjury  Auto accident MM/DD/CCYY)  46. Date of Accident (MM/DD/CCYY)  Auto Accident State  TREATING DENTIST AND TREATMENT LOCATION INFORMATION  53. Ihereby 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  54. NPI 1790716421  55. License Number  46. Provider Specially Code  47. Auto Accident State  TREATING DENTIST AND TREATMENT LOCATION INFORMATION  56. Aprovider Specially Code  48. NPI 1790716421  56. Address, City, State, Zip Code  Kenneth M. Sadler, DDS and Associates, PA  201 Charlois Boulevard  Winston-Salem, NC 27103	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15	16 34a. Diagn	osis Cod	de(s)	A		c		Fee(s)	
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 air or a portion of such charges. To the extent permitted by law, to 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  BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity) is not submitting claim on behalf of the patient or insured/subscriber.)  BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  BILLING DENTIST AND TREATMENT LOCATION INFORMATION  38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") 141. Date Appliance Placed (MM/DD/CCYY) 40. Is Treatment for Orthodontics?  All Date Appliance Placed (MM/DD/CCYY) 41. Date Appliance Placed (MM/DD/CCYY) 42. Months of Treatment for Orthodontics?  All Date Appliance Placed (MM/DD/CCYY) 42. Months of Treatment for Orthodontics?  All Date Appliance Placed (MM/DD/CCYY) 42. Months of Treatment for Orthodontics?  All Date Appliance Placed (MM/DD/CCYY) 42. Months of Treatment for Orthodontics?  All Date Appliance Placed (MM/DD/CCYY) 42. Months of Treatment for Orthodontics?  All Date Appliance Placed (MM/DD/CCYY) 42. Months of Treatment for Orthodontics?  All Date Appliance Placed	32 31 30 29 28 27 26 25 24 23 22 21 20 19 18	17 (Primary d	agnosis	s in " <b>A</b> ")	В		D		32. Total Fee	71.44
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 paractical algoerement 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/Quardian 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  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  38. Place of Treatment 11 (e.g. 11=cffice; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")  40. Is Treatment for Orthodontics?  41. Date Appliance Placed (MM/DD/CCYY)  42. Months of Treatment 1 11 (e.g. 11=cffice; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")  40. Is Treatment for Orthodontics?  41. Date Appliance Placed (MM/DD/CCYY)  42. Months of Treatment 1 1 (e.g. 11=cffice; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")  40. Is Treatment for Orthodontics?  42. Months of Treatment 1 1 (e.g. 11=cffice; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")  43. Replace of Treatment 1 1 (e.g. 11=cffice; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")  44. In the Appliance Placed (MM/DD/CCYY)  45. Treatment for Orthodontics?  46. Date of Accident (MM/DD/CCYY)  47. Auto Accident State  48. Date of Treatment 1 1 (e.g. 11=cffice; 22=O/P Hospital) (Use "Place of Service Codes for Professional C	35. Remarks									
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law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting at 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  BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  45. Treatment Resulting from Occupational illness/injury Auto accident Other accident (MM/DD/CCYY)  47. Auto Accident State  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  49. NPI 1790716421 55. License Number 56. Address, City, State, Zip Code  49. NPI 1144309410 4151 50. License Number 57. SSN or TIN 56-2132966  40. Is Treatment for Orthodontics?  40. Is Treatment for Orthodontics?  41. Date Appliance Placed (MM/DD/CCYY)  42. Months of Treatment of Prosthesis 44. Date of Prior Placement (MM/DD/CCYY)  45. Treatment Resulting from  Coccupational illness/injury Auto accident Cother accident (MM/DD/CCYY)  45. Treatment Resulting from  Coccupational illness/injury Auto accident Cother accident (MM/DD/CCYY)  46. Date of Accident (MM/DD/CCYY)  47. Auto Accident State  TREATING DENTIST AND TREATMENT LOCATION INFORMATION  59. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.  56. Address, City, State, Zip Code  49. NPI 1790716421 55. License Number Specialty Code 1223X0400X  56. Address, City, State, Zip C			38. 1	Place of Treatm	ent -	11 (e.g. 11	=office; 22=O/P H	ospital) 39	9. Enclosures (Y or N	)
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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  BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  8 Name, Address, City, State, Zip Code  Kenneth M. Sadler, DDS and Associates, PA 201 Charlois Boulevard Winston-Salem, NC 27103  42. Months of Treatment   43. Replacement of Prosthesis   14. 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    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    49. NPI   1790716421   55. License Number   56. Address, City, State, Zip Code   Specialty Code   1223X0400X   Specialty Code   1223X0400X   Winston-Salem, NC 27103	44/00			No (Skip	41-42	2) X Yes	(Complete 41-42	2) 4/2	20/2016	
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Subscriber Signature  Date  46. Date of Accident (MM/DD/CCYY)  47. Auto Accident State  TREATING DENTIST AND TREATMENT LOCATION INFORMATION  48. Name, Address, City, State, Zip Code  Kenneth M. Sadler, DDS and Associates, PA 201 Charlois Boulevard  Winston-Salem, NC 27103  To License Number  49. NPI 1144309410  4151  Auto Accident State  46. Date of Accident (MM/DD/CCYY)  47. Auto Accident State  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  54. NPI 1790716421  55. License Number Specialty Code 1223X0400X  201 Charlois Blvd Winston-Salem, NC 27103		o to me, amostry	45.	Treatment Resu	ulting fr	rom				
Subscriber Signature  Date  46. Date of Accident (MM/DD/CCYY)  47. Auto Accident State  47. Auto Accident State  48. Date of Accident (MM/DD/CCYY)  48. Name, Address, City, State, Zip Code  Kenneth M. Sadler, DDS and Associates, PA 201 Charlois Boulevard  Winston-Salem, NC 27103  49. NPI 1144309410  40. Date of Accident (MM/DD/CCYY)  46. Date of Accident (MM/DD/CCYY)  47. Auto Accident State  46. Date of Accident (MM/DD/CCYY)  47. Auto Accident State  48. Date of Accident (MM/DD/CCYY)  48. Date of Accident (MM/DD/CCYY)  49. Date of Accident (MM/DD/CCYY)  40. Date of Accident (MM/DD/CCYY)  40. Date of Accident (MM/DD/CCYY)  41. Auto Accident State  46. Date of Accident (MM/DD/CCYY)  47. Auto Accident State  48. Date of Accident (MM/DD/CCYY)  48. Date of Accident (MM/DD/CCYY)  49. NPI 1144309410  40. Date of Accident (MM/DD/CCYY)  4151  41. Auto Accident State  46. Date of Accident (MM/DD/CCYY)  47. Auto Accident State  48. Date of Accident (MM/DD/CCYY)  47. Auto Accident State  48. Date of Accident (MM/DD/CCYY)  47. Auto Accident State  48. Date of Accident (MM/DD/CCYY)  47. Auto Accident State  48. Date of Accident (MM/DD/CCYY)  48. Date of Accident (MM/DD/CCYY)  48. Date of Accident (MM/DD/CCYY)  49. NPI 1144309410  40. Date of Accident (MM/DD/CCYY)  4151  415. Date of Accident (MM/DD/CCYY)  417. Auto Accident (MM/DD/CCYY)  417. Auto Accident State  42. Date of Accident (MM/DD/CCYY)  42. Date of Accident (MM/DD/CCYY)  43. Date of Accident (MM/DD/CCYY)  44. Date of Accident (MM/DD/CCYY)  45. Date of Accident (MM/DD/CCYY)  47. Date of Accident (MM/DD/CC	x SIGNATURE ON FILE 11/28	3/2016		Occupati	ional ill	lness/injury	Auto	accident	Other accid	ent
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 1144309410  51. 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 1223X0400X  201 Charlois Blvd Winston-Salem, NC 27103	A		46. 1	Date of Acciden	nt (MM/	/DD/CCYY)			47. Auto Accid	lent State
1.0   1.0	BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dent	al entity is not	TRI	EATING DEN	NTIST	AND TRE	ATMENT LO	CATION II	INFORMATION	
X Dr. Martin Slominski	submitting claim on behalf of the patient or insured/subscriber.)		53.	I hereby certify	that the	e procedures	as indicated by	date are in p	progress (for procedu	res that require
201 Charlois Boulevard Winston-Salem, NC 27103    Signed (Treating Dentist)   Date	48. Name, Address, City, State, Zip Code		┨ '	multiple visits) o	or have	been compl	eted.			
201 Charlois Boulevard Winston-Salem, NC 27103  Signed (Treating Dentist)  54. NPI 1790716421  55. License Number  56. Address, City, State, Zip Code  49. NPI  1144309410  50. License Number  51. SSN or TIN  56-2132966  Signed (Treating Dentist)  56. License Number  56. Address, City, State, Zip Code  56a. Provider Specialty Code 1223X0400X  201 Charlois Blvd Winston-Salem, NC 27103	Kenneth M. Sadler, DDS and Associates, PA		<sub>Y</sub>	Dr. Martin	Slo	minski			11/28/2016	•
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111.	Other Insurance Company	/Dental	Benefit	Pian Na	me, Address,	City, State	e, Zip Code			WINSTON	N SAL	.⊨M, NC 2	2/106				
ı								21	1. Date of Birtl	2 (MM/F	DD/CCVV)	22. Gender	23 Patie	ant ID/Ac	count # (Assi	igned by Dentist)	
l								- 1	04/28/200	-	00/0011)	M X F	1		,	gried by Deritist)	
<b> </b>	CORD OF SERVICES	IDED											10000.				
Ϊ́	24. Procedure Date	25. Area	26.	2	7. Tooth Numbe	er(s)	28. Tooth	29. Pro	cedure	29a. Diag.	29b.						
Ш	(MM/DD/CCYY)	of Oral Cavity	Tooth System		or Letter(s)	(-)	Surface	Co		Pointer	Qty.		30. De	escription			31. Fee
1	11/28/2016							D867	0			PERIOD	ORTHO TX I	NSTALLI	MENT		206.25
2																	
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4																	
5																	
6																	
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9								-									
10																	
33	Missing Teeth Information	(Place a	ın "X" oı	n each m	issing tooth.)	)	1	I 34. Diagnosis	s Code	List Qualifier		( ICD-9 =	B; ICD-10 = AB )		31	a. Other	
Г		6 7		9 10	11 12 1			34a. Diagnos			Α					Fee(s)	
Г	32 31 30 29 28 2	7 26	25 2	4 23	22 21 2	0 19 1	8 17 (	Primary dia	gnosis	in " <b>A</b> ")	В		D		32	. Total Fee	206.25
35	Remarks						'									'	
L																	
-	JTHORIZATIONS					1 4-	h	I. f II	-				NT INFORMAT		FI	0/ ND	
36	I have been informed of the charges for dental services	and ma	iterials r	ot paid b	y my dental b	enefit plai	n, unless pro	hibited by	38. F		_		=office; 22=O/P Hos rofessional Claims")	spital) 39.	Enclosu	ires (Y or N)	
l	law, or the treating dentist of or a portion of such charge	s. To the	extent	permitte	d by law, I cor	nsent to yo	ur use and d	isclosure	40.16	s Treatment fo			, ordered and ordered a		ate Annli	iance Placed	(MM/DD/CCYY)
L	of my protected health info			out payr	nent activities		tion with this /28/2016		40.1	No (Ski			(Complete 41-42)		/2016	ance i laced	(WIWI/DD/CCTT)
X	SIGNATURE Patient/Guardian Signature					Dat			42. N	Months of Trea			cement of Prosthe			ior Placemen	it (MM/DD/CCYY)
27	I hereby authorize and dire		nent of	he dont	l hanafita att			directly	-	12		No	Yes (Complete				,
3/	to the below named dentis				n penents oth	iei wise pa	yable to IIIE,	unecuy	45. T	reatment Res	ulting fr	om					
$ _{x}$	SIGNATURE	ON	FILF			11	/28/2016			Occupa	tional ill	ness/injury	Auto ad	ccident		Other accider	nt
Ľ	Subscriber Signature					Dat			46. E	ate of Accide	nt (MM/	DD/CCYY)			47.	Auto Accide	ent State
	LLING DENTIST OR DENTIST OR DENTITY OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF THE COMMENT OF T					dentist or o	dental entity	is not	TRE	ATING DE	NTIST	AND TRE	ATMENT LOC	ATION IN	IFORM.	ATION	
╙				surea/su	oscriber.)					hereby certify nultiple visits)			as indicated by d	ate are in pr	rogress (	for procedure	es that require
	Name, Address, City, State				DA				"	nampie visits)	Ji ilave	, seem compr	otou.				
	enneth M. Sadler, DD 01 Charlois Boulevard		ASSO	ciates,	PA				X_	Dr Debor					11/:	28/2016	
	inston-Salem, NC 27								54 N	Signed (Treation   14574			55	License Nu	ımher	Date	
									-	ddress, City,						204000	
49	NPI	50	License	Numbe	r	51. SSN	or TIN		-	Charlois Blv			Spe	ecialty Code	1223	3X0400X	
	44309410	41		, , anibe		56-213				ston-Salem,		103					
52	Phone Number (336) 331-35	500			52a. Additio Provide	nal			57. F	Phone Number (33	36) 33	1-3500	58.	Additional Provider ID	`		

ADA American Dental Association Denta	Claim F	orm							
HEADER INFORMATION									
Type of Transaction (Mark all applicable boxes)									
X Statement of Actual Services Request for Predetermination/F	Preauthorization								
X EPSDT / Title XIX									
2. Predetermination/Preauthorization Number		F	POLICYHOLI	DER/S	UBSCRIB	ER INFORMA	TION (For Ir	Insurance Company N	lamed in #3)
		1	12. Policyholder	/Subsc	riber Name (	Last, First, Midd	le Initial, Suffi	ix), Address, City, Sta	te, Zip Code
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATIO	N		CDEICHT	C 1/E					
3. Company/Plan Name, Address, City, State, Zip Code			SPEIGHTS 4840 BAR	,					
BCBSNC, CLAIMS UNIT			WINSTON			27106			
PO BOX 2100			WINSTON	I-SAL	_EIVI, INC	27 100			
WINSTON-SALEM, NC 27102		1	13. Date of Birth	(MM/E	DD/CCYY)	14. Gender	15. Polic	cyholder/Subscriber II	O (SSN or ID#)
			11/25/196	5		$X^{M}$	F W136	694110	
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none	e, leave blank.)	1	16. Plan/Group I	Numbe	er 1	7. Employer Na	me		
4. Dental? Medical? (If both, complete 5-11 for dental of	only.)		080960		F	REYNOLDS	3		
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		F	PATIENT INF	ORM	ATION				
		1	18. Relationship	to Poli	icyholder/Sub	scriber in #12 A	bove		ed For Future
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subsci	riber ID (SSN or IE	#)	Self	Sp	oouse X	Dependent Chi	ld Othe	er Use	
	·	2	20. Name (Last,	First, N	Middle Initial,	Suffix), Address	, City, State, 2	Zip Code	
9. Plan/Group Number 10. Patient's Relationship to Person name	ed in #5		SPEIGHTS	S KE	NADY				
Self Spouse Depend	lent Other		4840 BAR	,					
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, 2	Zip Code		WINSTON			27106			
					•				
	2	21. Date of Birth	(MM/E	DD/CCYY)	22. Gender	23. Patie	ent ID/Account # (Assi	gned by Dentist)	
			06/30/200	1		$\square$ M $\square$	F 80333	32162892	
RECORD OF SERVICES PROVIDED							ı		
24 Procedure Date 25. Area 26. 27 Tooth Number(s)	28. Tooth 29.	Procedure	e 29a. Diag.	29b.					
(MM/DD/CCYY) of Oral Tooth Cavity System or Letter(s)	Surface	Code	Pointer	Qty.		30.	Description		31. Fee
1 11/28/2016	D8	370			PERIOD	ORTHO TX	INSTALL	.MENT	206.25
2									
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6									
7									
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10									
33. Missing Teeth Information (Place an "X" on each missing tooth.)	34. Diagr	osis Code	e List Qualifier		( ICD-9 =	B; ICD-10 = AB	)	31a. Other	
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15	16 34a. Diag			<u></u>	(1111	C	,	Fee(s)	
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18	17 (Primary	diagnosis	s in " <b>A</b> ")	В				32. Total Fee	206.25
35. Remarks	, ,		<u> </u>	<u> </u>					200.20
AUTHORIZATIONS		AN	ICILLARY CL	AIM/	TREATME	NT INFORMA	TION		
36. I have been informed of the treatment plan and associated fees. I agree to be			Place of Treatm	ent	11 (e.g. 11	=office; 22=O/P H	ospital) 39.	. Enclosures (Y or N)	
charges for dental services and materials not paid by my dental benefit plan, ulaw, or the treating dentist or dental practice has a contractual agreement with			(Use "Place of	of Service	ce Codes for P	rofessional Claims	3")		
or a portion of such charges. To the extent permitted by law, I consent to your of my protected health information to carry out payment activities in connection	use and disclosure	_	Is Treatment for	r Ortho	dontics?		41. D	Date Appliance Placed	(MM/DD/CCYY)
14/0	8/2016		No (Skip	0 41-42	2) X Yes	(Complete 41-42	2)   1/1!	5/2015	
X SIGNATURE ON FILE 11/2 Patient/Guardian Signature Date	0/2010	- <del> </del> 42.	Months of Treat	tment	43. Repla	cement of Prosth		Date of Prior Placemen	t (MM/DD/CCYY)
27. I havely suth arise and direct normant of the dentel haveful athernia and	blata waa diwaati.	-	1		No	Yes (Comple	te 44)		
37. I hereby authorize and direct payment of the dental benefits otherwise payal to the below named dentist or dental entity.	bie to me, directly	45.	Treatment Resu	ulting fr	om				
V SIGNATURE ON EUR 11/2	8/2016		Occupat	ional ill	ness/injury	Auto	accident	Other accider	nt
X SIGNATURE ON FILE 11/2 Subscriber Signature Date	0/2010	- <del>  4</del> 6.	Date of Acciden	nt (MM/	DD/CCYY)			47. Auto Accide	nt State
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or der	TR	EATING DEN	NTIST	AND TRE	ATMENT LO	CATION IN	NFORMATION		
submitting claim on behalf of the patient or insured/subscriber.)							progress (for procedure	es that require	
48. Name, Address, City, State, Zip Code		multiple visits)				J P	2 Ver Presentation		
	Cenneth M. Sadler, DDS and Associates, PA							11/20/2016	
201 Charlois Boulevard	01 Charlois Boulevard							11/28/2016 Date	
Winston-Salem, NC 27103		54.	Signed (Treat			5	5. License Nu		
			Address, City, S			- 1		e 1223X0400X	
49. NPI 50. License Number 51. SSN or	TIN	_	1 Charlois Blvo			[8	pecially Code	# 1220/10 <del>1</del> 00/	
1144309410 4151 56-21329			nston-Salem, N		103				
52. Phone (326) 321 3500   52a. Additional		57.	Phone (33	6) 33	1-3500	5	8. Additional	903HC	
Number (336) 331-3300 Provider ID			Number (33	2, 50	. 5555		Provider ID	, 000110	

ADA American Dental Association® Dental Claim I	Form								
HEADER INFORMATION									
Type of Transaction (Mark all applicable boxes)									
X Statement of Actual Services Request for Predetermination/Preauthorization	1								
X EPSDT / Title XIX									
2. Predetermination/Preauthorization Number					ER INFORMAT				
		12. Policyholde	r/Subsc	riber Name (	Last, First, Middle	Initial, Suf	ffix), Addres	s, City, Sta	te, Zip Code
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		BURKEY,	, KEV	'IN					
3. Company/Plan Name, Address, City, State, Zip Code		1324 ROE	BINH	OOD FO	REST DR				
BCBSNC, CLAIMS UNIT PO BOX 2100		PFAFFTC	OWN,	NC 2704	10				
WINSTON-SALEM, NC 27102	ŀ	13. Date of Birtl	h (MM/I	OD/CCYY)	14. Gender	15 Pol	licyholder/Si	ubscriber II	O (SSN or ID#)
,		04/01/196	•	,	XMF	.	694414		(00.10.10.10.1)
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)		16. Plan/Group		r /	17. Employer Nam		004414		
4. Dental? Medical? (If both, complete 5-11 for dental only.)		080960			RAI				
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		PATIENT IN	FORM	ATION					
	Ī	18. Relationship	p to Poli	icyholder/Sul	oscriber in #12 Ab	ove	1		ed For Future
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN or	· ID#)	Self	S	oouse X	Dependent Child	d Oth	ier	Use	
M F		20. Name (Last	, First, I	Middle Initial,	Suffix), Address,	City, State	, Zip Code		
9. Plan/Group Number 10. Patient's Relationship to Person named in #5		BURKEY,	, MILE	ES D					
Self Spouse Dependent Other	r	1324 ROE							
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code		PFAFFTC	)WN,	NC 2704	0				
		24 Data of Dist	- /BABA/F	20/00/0/	22 Candar	22 De4	tiant ID/Acce		and by Dantiet
		21. Date of Birtl 06/08/200		DD/CCYY)	22. Gender		12016289		gned by Dentist)
RECORD OF CERVICES PROVIDED		00/00/200	<i>-</i> 1		<u> </u>	10000	201020		
RECORD OF SERVICES PROVIDED  24. Procedure Date   25. Area   26.   27. Tooth Number(s)   28. Tooth   2	29. Procedur	ire 29a. Diag.	29b.						
24. Procedure Date (MM/DD/CCYY) Code 1 Tooth (MM/DD/CCYY) Cavity System 27. Tooth Number(s) 28. Tooth 29. Tooth System 27. Tooth Number(s) 28. Tooth Surface 29. Tooth System 29. Tooth Number(s) 28. Tooth System 29. Tooth Number(s) 29.	Code	Pointer	Qty.		30. D	escription			31. Fee
1 11/28/2016 D	08670			PERIOD	ORTHO TX	INSTALI	LMENT		199.58
2									
3									
4									
5									
6									
7									
8									
9									
33. Missing Teeth Information (Place an "X" on each missing tooth.) 34. Dia	anosis Co	de List Qualifier		/ ICD 9 =	B; ICD-10 = AB )		312	. Other	
	iagnosis Co		A	(100-9 -	C			Fee(s)	
	ry diagnos	. ,	Α		O		32.	Total Fee	199.58
35. Remarks	, ,	,							100.00
AUTHORIZATIONS	Al	NCILLARY C	LAIM/	TREATME	NT INFORMAT	TION			
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for a charges for dental services and materials not paid by my dental benefit plan, unless prohibited			_		=office; 22=O/P Ho		9. Enclosure	es (Y or N)	
law, or the treating dentist or dental practice has a contractual agreement with my plan prohibition a portion of such charges. To the extent permitted by law, I consent to your use and disclosi	ing all				rofessional Claims")				
of my protected health information to carry out payment activities in connection with this claim.		). Is Treatment fo			(0 1 1 11 10)			nce Placed	(MM/DD/CCYY)
X SIGNATURE ON FILE 11/28/2016	_	No (Ski			(Complete 41-42)		7/2015	- Diagona	+ (MMM/DD/COXXX)
Patient/Guardian Signature Date		2. Months of Trea 6	atment	43. Repla	cement of Prosthe Yes (Complete		Date of Prior	r Placemen	t (MM/DD/CCYY)
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, direct to the below named dentist or dental entity.		5. Treatment Res	ulting fr		Tes (Complete	(44)			
	"		-	ness/injury	Auto a	ccident	Ot	her accider	nt
X SIGNATURE ON FILE 11/28/2016 Subscriber Signature Date	$ \frac{1}{46}$	S. Date of Accide	nt (MM/	DD/CCYY)			47. A	Auto Accide	nt State
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not	_		,		ATMENT LOC	ATION I			
submitting claim on behalf of the patient or insured/subscriber.)					as indicated by d				es that require
48. Name, Address, City, State, Zip Code		multiple visits)	or have	been compl	eted.				
Kenneth M. Sadler, DDS and Associates, PA	>	x Dr Debor	ah F	Novak			11/2	8/2016	
201 Charlois Boulevard Winston-Salem, NC 27103	Ľ	Signed (Trea	ating De	ntist)				ate	
This is a saiding the Er iso		<sup>1. NPI</sup> 14574				. License N			
	_	S. Address, City,		ip Code	56a   Sp	a. Provider ecialty Cod	te 1223)	K0400X	
49. NPI 50. License Number 51. SSN or TIN		01 Charlois Blv /inston-Salem,		103					
1144309410 4151 56-2132966 52. Phone (336) 331 3500 52a. Additional		7. Dhana			50	. Additional	ı		
Number (336) 331-3500 Sza. Additional Provider ID	37	Number (33	36) 33	1-3500		Provider I	iD		

ADA American Dental Association Denta	il Claim Fo	rm							
HEADER INFORMATION									
Type of Transaction (Mark all applicable boxes)									
X Statement of Actual Services Request for Predetermination/	/Preauthorization								
X EPSDT / Title XIX									
2. Predetermination/Preauthorization Number		P	POLICYHOLI	DER/S	UBSCRIB	ER INFORMAT	ION (For Insura	ance Company N	lamed in #3)
		1	12. Policyholder	/Subsc	riber Name (	Last, First, Middle	Initial, Suffix), A	ddress, City, Sta	te, Zip Code
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	ON		CTUDTEV	/ A B I T	- EDIO				
3. Company/Plan Name, Address, City, State, Zip Code			STURTEV 445 WARF		,	DD			
Blue Cross Blue Shield			UNION GF		_				
P O Box 75			UNION G	\Ovi	E, INC 20	009			
Minneapolis, MN 55440-0075		1	13. Date of Birth	(MM/E	DD/CCYY)	14. Gender	15. Policyhol	lder/Subscriber II	D (SSN or ID#)
			11/11/196	7		XMF	F793603	313	
OTHER COVERAGE (Mark applicable box and complete items 5-11. If nor	ne, leave blank.)	1	16. Plan/Group I	Numbe	r 1	7. Employer Nam	 e		
4. Dental? Medical? (If both, complete 5-11 for dental	only.)		FEPBD1-	0002	F	EDERAL G	OVERNME	:NT	
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		F	PATIENT INF	ORM	ATION				
		1	18. Relationship	to Poli	cyholder/Sub	scriber in #12 Abo	ove	19. Reserv	ed For Future
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subsc	criber ID (SSN or ID	<b>‡</b> )	Self	Sp	oouse X	Dependent Child	Other	Use	
M   F		′ <b>⊢</b>	20. Name (Last,	First, N	Middle Initial,	Suffix), Address,	City, State, Zip (	Code	
9. Plan/Group Number 10. Patient's Relationship to Person nam	ed in #5		STURTEV	ΊΔΝΤ	MORGA	N			
Self Spouse Depen	dent Other		445 WARF		,				
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State,	Zip Code		UNION GF						
					_,				
		2	21. Date of Birth	(MM/E	DD/CCYY)	22. Gender	23. Patient II	D/Account # (Assi	igned by Dentist)
			02/26/200	3		M X F	8051131	62890	
RECORD OF SERVICES PROVIDED									
24 Procedure Date 25. Area 26. 27 Tooth Number(e)	28. Tooth 29. F	rocedure	29a. Diag.	29b.					
(MM/DD/CCYY) of Oral Tooth Cavity System or Letter(s)		Code	Pointer	Qty.		30. De	scription		31. Fee
1 11/28/2016	D86	70			PERIOD	ORTHO TX I	NSTALLME	NT	105.42
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3									
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8			+ +						
9									
10									
33. Missing Teeth Information (Place an "X" on each missing tooth.)	34 Diagn	sis Code	e List Qualifier		(ICD-9 =	B; ICD-10 = AB )		31a. Other	
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15					(100-0-	C		Fee(s)	
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18			- i «A"\	^				32. Total Fee	105.42
35. Remarks	ir (i rimary	ilagi ioolo	, , , , , , , , , , , , , , , , , , ,	В		D			103.42
AUTHORIZATIONS		IΔN	ICII I ARY CI	ΔIM/	TREATME	NT INFORMAT	ION		
36. I have been informed of the treatment plan and associated fees. I agree to be	e responsible for all	-	Place of Treatm			=office; 22=O/P Hos		closures (Y or N)	
charges for dental services and materials not paid by my dental benefit plan, law, or the treating dentist or dental practice has a contractual agreement with	unless prohibited by	- 1				rofessional Claims")	, ,		
or a portion of such charges. To the extent permitted by law, I consent to you	r use and disclosure	_	Is Treatment for	r Ortho	dontics?		41. Date A	Appliance Placed	I (MM/DD/CCYY)
of my protected health information to carry out payment activities in connection	on with this claim. 28/2016		No (Skip			(Complete 41-42)	5/18/20		(
X SIGNATURE ON FILE 11/2 Patient/Guardian Signature Date		- 42.1	Months of Treat			cement of Prosthe			nt (MM/DD/CCYY)
			29		No	Yes (Complete			(
37. I hereby authorize and direct payment of the dental benefits otherwise paya to the below named dentist or dental entity.	able to me, directly	45	Treatment Resu	ıltina fr			.,		
·	00/0046	''		-	ness/injury	Auto ad	cident [	Other accider	nt
X SIGNATURE ON FILE 11/2 Subscriber Signature Date	28/2016	- 46	Date of Accider				L	47. Auto Accide	ent State
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or de	_		•		ATMENT LOC	ATION INFO		on otate	
submitting claim on behalf of the patient or insured/subscriber.)	- ⊢				as indicated by d			es that require	
48. Name, Address, City, State, Zin Code	18. Name, Address, City, State, Zip Code							oo (ioi proceduli	oo alaa require
	Kenneth M. Sadler, DDS and Associates, PA							11/00/0010	
201 Charlois Boulevard		X	Dr. Martin Signed (Treat				•	11/28/2016 Date	
Winston-Salem, NC 27103		54	NPI 17907			55	License Numbe		
			Address, City, S			I			
49. NPI 50. License Number 51. SSN or	r TIN	_	Address, City, S 1 Charlois Blvo		.p code	Spe	cialty Code 12	ZZ3XU4UUX	
49. NPI 50. License Number 51. SSN or 1144309410 4151 56-2132			nston-Salem, N		103				
52. Phone (226) 224 2500   52a. Additional		57. 1	Phone (22			1 58.	Additional O	02110	
Number (336) 331-3500 Sza. Additional Provider ID			Number (33	0) 33	1-3500	36.	Additional 90 Provider ID	UJHU	

ADA American Dent	ai Assoc	lation <b>Dent</b>	ai Ciain	1 Forr	n								
HEADER INFORMATION													
Type of Transaction (Mark all application)	cable boxes)												
X Statement of Actual Services	Re	quest for Predetermination	n/Preauthorizat	tion									
X EPSDT / Title XIX													
2. Predetermination/Preauthorization	Number				P	OLICYHOL	DER/S	UBSCRIB	ER INFORMA	TION (For	r Insurance	e Company N	lamed in #3)
					12	2. Policyholder	r/Subsc	riber Name (	Last, First, Middl	e Initial, Su	uffix), Addr	ess, City, Sta	te, Zip Code
INSURANCE COMPANY/DENT	TAL BENEF	IT PLAN INFORMAT	ION		٦,	MADOLLI	I						
3. Company/Plan Name, Address, Cit	y, State, Zip C	ode				MARSH, I 245 SHAL			NI.				
BLUE CROSS BLUE SH	IIELD					MOUNT A	_	-					
P O BOX 659444					'	INIOUNT A	MITA I ,	NC 2703	50				
SAN ANTONIO, TX 7826	35				13	3. Date of Birth	n (MM/E	DD/CCYY)	14. Gender	15. Po	olicyholder	/Subscriber II	O (SSN or ID#)
						11/06/197	77		M X	F GUK	K918A7	6090	
OTHER COVERAGE (Mark applic	cable box and	complete items 5-11. If n	one, leave blan	k.)	16	6. Plan/Group	Numbe	er '	17. Employer Na	me			
4. Dental? Medical?	(If bot	h, complete 5-11 for dent	al only.)		1	GA7147N	1007		MT AIRY DI	ALYSIS	3		
5. Name of Policyholder/Subscriber in	#4 (Last, Firs	t, Middle Initial, Suffix)			P/	ATIENT INF	FORM	ATION					
					18	8. Relationship	to Poli	icyholder/Sul	oscriber in #12 Al	bove		19. Reserv	ed For Future
6. Date of Birth (MM/DD/CCYY)	7. Gender	8. Policyholder/Sub	scriber ID (SSN	l or ID#)	1	Self	Sp	oouse X	Dependent Chil	d Oth	her	Use	
	M i	F	•		20	0. Name (Last,	First, N	Middle Initial,	Suffix), Address	, City, State	e, Zip Code	e	
9. Plan/Group Number	10. Patient's F	Relationship to Person na	med in #5		1	MARSH, O	CLOF	: D					
	Self	Spouse Depe	endent O	ther		245 SHAL			.N				
11. Other Insurance Company/Dental	Benefit Plan N	lame, Address, City, Stat	e, Zip Code		1	MOUNT A	AIRY,	NC 2703	0				
		21	1. Date of Birth	n (MM/E	DD/CCYY)	22. Gender	23. Pa	atient ID/Ac	count # (Assi	gned by Dentist)			
			12/14/200	)5		M X	F  8051	142162	889				
RECORD OF SERVICES PROV	/IDED								<u> </u>				
24. Procedure Date 25. Area		27. Tooth Number(s)	28. Tooth	29. Proce	dure	29a. Diag.	29b.		20.5				04 5
(MM/DD/CCYY) of Oral Cavity		or Letter(s)	Surface	Code		Pointer	Qty.		30. [	Description			31. Fee
1 11/28/2016				D8670				PERIOD	ORTHO TX	INSTAL	LMENT	•	199.58
2													
3													
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7													
8													
9													
10													
33. Missing Teeth Information (Place a	an "X" on each	missing tooth.)	34.	Diagnosis (	Code	List Qualifier		( ICD-9 =	B; ICD-10 = AB	)	31	1a. Other	
1 2 3 4 5 6 7	8 9 10	) 11 12 13 14 1	5 16 34a	a. Diagnosis	Code	le(s)	Α		C			Fee(s)	
32 31 30 29 28 27 26	25 24 23	3 22 21 20 19 1	8 17 (Pri	imary diagn	osis i	in " <b>A</b> ")	В		D		32	2. Total Fee	199.58
35. Remarks													
AUTHORIZATIONS					ANC	CILLARY CL	LAIM/	TREATME	NT INFORMA	TION			
36. I have been informed of the treatm					38. P	Place of Treatm	nent [	11 (e.g. 11	=office; 22=O/P H	ospital) 3	39. Enclosu	ures (Y or N)	
charges for dental services and ma law, or the treating dentist or dental	practice has a	contractual agreement w	th my plan proh	ibiting all		(Use "Place	of Service	ce Codes for P	rofessional Claims	")			
or a portion of such charges. To the of my protected health information					40. Is	s Treatment fo	r Ortho	dontics?		41.	. Date Appl	liance Placed	(MM/DD/CCYY)
X SIGNATURE ON		-	/28/2016			No (Ski	p 41-42	2) X Yes	(Complete 41-42	8/:	/30/2016	6	
Patient/Guardian Signature		Dat	е		42. N	Months of Trea	tment	43. Repla	cement of Prosth	esis 44.	. Date of Pr	rior Placemen	t (MM/DD/CCYY)
37. I hereby authorize and direct payr	nent of the der	ntal benefits otherwise pa	vable to me. dir	rectly		20		No [	Yes (Complet	e 44)			
to the below named dentist or den			,,		45. T	reatment Res	ulting fr	om					
X SIGNATURE ON	FILE	11	/28/2016			Occupat	tional ill	ness/injury	Auto	accident		Other accider	nt
Subscriber Signature	\ <u> </u>						nt (MM/	DD/CCYY)			47	. Auto Accide	nt State
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not						EATING DE	NTIST	AND TRE	ATMENT LO	CATION	INFORM	IATION	
submitting claim on behalf of the patie	Ī					as indicated by	date are in	progress	(for procedure	es that require			
48. Name, Address, City, State, Zip C	ode				n	nultiple visits)	or have	been compl	eted.				
	enneth M. Sadler, DDS and Associates, PA						slo	minski			11/	28/2016	
201 Charlois Boulevard							ting De					Date	
Winston-Salem, NC 27103					54. N	NPI 17907	1642	21	I .	5. License N			
					56. A	Address, City, S	State, Z	ip Code	56 Si	a. Provider pecialty Co	er ode 1223	3X0400X	
49. NPI 50.	License Numb	per 51. SSN	or TIN			Charlois Blv			ات.	, 200			
1144309410 41	51	56-213	2966		Wins	ston-Salem, I	NC 27	103					
52. Phone Number (336) 331-3500		52a. Additional Provider ID			57. P N	Phone Number (33	36) 33	1-3500	58	B. Additiona Provider	al 9031	HC	

2	ADA American Dental Association	Dentai Ciaim	Form							
	HEADER INFORMATION									
POLICYHOLDERSUBSORIBER INFORMATION   The Invasional Company Memorial in R)	Type of Transaction (Mark all applicable boxes)									
POLICYPROCERSUSSCRIPER INFORMATION INTO Financian Contravery News of in 92)   Policy Process (Process of the MANAGORD COURT CLERNMONS) N. CZ 2702	X Statement of Actual Services Request for Prede	termination/Preauthorization	on							
INSURANCE COMMAY/DBATAL SEMENT PLAN INFORMATION   1. Contraspriphen from Address Cry State, 2 Code   1. Commany Plan from Address Cry State, 2 Code   1. Commany Plan from Address Cry State, 2 Code   1. Commany Plan from Address Cry State, 2 Code   1. Commany Plan from Address Cry State, 2 Code   1. Commany Plan from Address Cry State, 2 Code   1. Commany Plan from Address Cry State, 2 Code   1. Commany Plan from Address Cry State, 2 Code   1. Commany Plan from Address Cry State, 2 Code   1. Code   1	X EPSDT / Title XIX									
	2. Predetermination/Preauthorization Number			POLICYHOLI	DER/S	UBSCRIB	ER INFORMAT	ION (For Insu	ırance Company N	lamed in #3)
				12. Policyholder	/Subsc	riber Name (	Last, First, Middle	Initial, Suffix),	Address, City, Sta	te, Zip Code
S. Contemptiffor Name. Address. C.N.S. State, 2 P. Code   P. O. D. X. 2100   T. S. Park Park Park Park Park Park Park Park	INSURANCE COMPANY/DENTAL BENEFIT PLAN INF	ORMATION		DUAN UI	INIC	N A				
CLEMMONS, NC 277012   CLEMMONS, NC 277012   13 Date a filter (MARCIDICOTY)   14. Garder   15. Filter) policy (MISSO 419   15	3. Company/Plan Name, Address, City, State, Zip Code			•			DT			
Some of Birth MMCDICCTY    16. Gender   15. Policiphides/Devictor ID (SSN of IDN)	BLUE CROSS BLUE SHIELD OF NC									
O1/15/1961       W        W        W        W        W        W        W        W        W        W        W        W        W          W          W            W	P O BOX 2100			CLEIVIIVIOI	INO, I	NC 27012	<u> </u>			
OFFICE COVERAGE   Part against leave and complete for the desire of the desire of the foliation   Control   Contro	WINSTON-SALEM, NC 27102			13. Date of Birth	(MM/E	DD/CCYY)	14. Gender	15. Policyh	older/Subscriber II	D (SSN or ID#)
4. Detailed				01/15/196	31		X M F	W1369	5419	
## ATTENT INFORMATION    Part    OTHER COVERAGE (Mark applicable box and complete items	5-11. If none, leave blank.	.)	16. Plan/Group I	Numbe	r 1	7. Employer Nam	ne .			
Second Birth (MMDDICCYY)   7. Gender   8. Policyhoder/Ruberchier ID (SSN or IDe)   9. Pain/Group Number   10. Patient's Redistriction ple Particul network of the SSN or IDe)   10. Patient's Redistriction ple Particul network of the SSN or IDE)   10. Patient's Redistriction ple Particul network of the SSN or IDE)   11. Other Insurance Company/Dental Berneti Plan Name, Address, City, State, 20 Code   PHAN, EMILY K (SSR SER, EMICE RUN COURT CLEMMONS, NC 27012   11. Other Insurance Company/Dental Berneti Plan Name, Address, City, State, 20 Code   PHAN, EMILY K (SSR SER)   11. Other Insurance Company/Dental Berneti Plan Name, Address, City, State, 20 Code   PHAN, EMILY K (SSR SER)   11. Other Insurance Company/Dental Berneti Plan Name, Address, City, State, 20 Code   PHAN, EMILY K (SSR SER)   11. Other Insurance Company/Dental Berneti Plan Name, Address, City, State, 20 Code   PHAN, EMILY K (SSR SER)   11. Other Insurance Company/Dental Berneti Plan Name, Address, City, State, 20 Code   PHAN, EMILY K (SSR SER)   11. Other Insurance Company/Dental Berneti Plan Name, Address, City, State, 20 Code   PHAN, EMILY K (SSR SER)   11. Other Insurance Company/Dental Berneti Plan Name, Address, City, State, 20 Code   PHAN, EMILY K (SSR SER)   11. Other Insurance Company/Dental Berneti Plan Name, Address, City, State, 20 Code   11. Other Address, City, State, 20 Code   11. Other Address, City, State, 20 Code   11. Other Address, City, State, 20 Code   11. Other Address, City, State, 20 Code   11. Other Address, City, State, 20 Code   11. Other Address, City, State, 20 Code   11. Other Address, City, State, 20 Code   11. Other Address, City, State, 20 Code   11. Other Address, City, State, 20 Code   11. Other Address, City, State, 20 Code   11. Other Address, City, State, 20 Code   11. Other Address, City, State, 20 Code   11. Other Address, City, State, 20 Code   11. Other Address, City, State, 20 Code   11. Other Address, City, State, 20 Code   11. Other Address, City, State, 20 Code   11. Other Address, City, State, 20 Code	4. Dental? Medical? (If both, complete 5-1	1 for dental only.)		080960		F	RAI			
Control of Sirri (MMODICCYY)   7, Conder   M   F   8, Policy/tolder/Subscriber ID (SSN or IDF)   20   Species   Control of Control	5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial	Suffix)		PATIENT INF	ORM	ATION				
Collect of Birth (MMODICCYY)			Ī	18. Relationship	to Poli	icyholder/Sub	scriber in #12 Ab	ove	19. Reserv	ed For Future
9. Plan/Grup Number	6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyh	older/Subscriber ID (SSN o	or ID#)	Self	Sp	oouse X	Dependent Child	Other	Use	
Self   Social   Dependent   Other   0682 RIDGE RUN COURT   CLEMMONS, NC 27012   22 Gender   Dependent   Dependent   Other   CLEMMONS, NC 27012   22 Gender   Dependent   Dep		·		20. Name (Last,	First, I	Middle Initial,	Suffix), Address,	City, State, Zip	Code	
11. Cited Insurance Company/Dental Benefit Flan Name, Address, City, State, Zip Code   21. Date of Birth, MINDIDCCYY)   22. Cender   23. Patient (DiAccount B (Assigned by Dentist)	9. Plan/Group Number 10. Patient's Relationship to	Person named in #5		PHAN. FM	III Y I	K				
CLEMMONS, NC 27012	Self Spouse	Dependent Oth	ner	,			RT			
RECORD OF SERVICES PROVIDED	11. Other Insurance Company/Dental Benefit Plan Name, Address,	City, State, Zip Code								
RECORD OF SERVICES PROVIDED										
RECORD OF SERVICES PROVIDED   24   Procedure Date   CANNEL   South   CANNEL   South   CANNEL   South   CANNEL				21. Date of Birth	(MM/E	DD/CCYY)	22. Gender	23. Patient	ID/Account # (Assi	igned by Dentist)
Part   Part				02/07/200	3		M X F	805135	162888	
All procedure law   System	RECORD OF SERVICES PROVIDED									
MINIODICCYY		er(s) 28. Tooth	29. Procedure	re 29a. Diag.	29b.		20 D			24 5
2	(MM/DD/CCVV)   Ol Olai   100th   or Letter(s)		Code	Pointer	Qty.		30. D	escription		31. Fee
3	1 11/28/2016		D8670			PERIOD	ORTHO TX	INSTALLMI	ENT	275.00
A	2									
S	3									
Record   Company   Compa	4									
7	5									
Solution   Solution	6									
Solution   Solution	7									
10	8									
3. Missing Teeth Information (Place an "X" on each missing tooth.)  1 2 3 4 5 6 7 8 9 9 10 11 12 13 14 15 16 34a. Diagnosis Code(s)  3. 2 31 30 29 28 27 26 25 24 23 22 21 20 19 8 8 7 (Primary diagnosis in "A")  3. Remarks    AUTHORIZATIONS   ACCOUNTY   AUTHORIZATION   A	9									
1	10									
32 31 30 28 28 27 26 25 24 23 22 21 20 19 18 17   (Primary diagnosis in "A")   B   D   32. Total Fee   275.00	33. Missing Teeth Information (Place an "X" on each missing tooth.	34. D	Diagnosis Cod	de List Qualifier		( ICD-9 =	B; ICD-10 = AB )			
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, crite 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, crite 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, crossent to your up any discholar to carry out payment activities in connection with this claim.  X SIGNATURE ON FILE 11/28/2016 Patient/Guardian Signature Date 11/28/2016 Subscriber Signature Date 11/28/2016 Subscriber Signature Date 11/28/2016 Subscriber Signature Date 11/28/2016 Subscriber Signature Date 11/28/2016 Subscriber Signature Date 11/28/2016 Subscriber Signature Date 11/28/2016 Subscriber Signature Date 11/28/2016 Subscriber Signature Date 11/28/2016 Subscriber Signature Date 11/28/2016 Subscriber Signature Date 11/28/2016 Subscriber Signature Date 11/28/2016 Subscriber Signature Date 11/28/2016 Subscriber Signature Date 11/28/2016 Subscriber Signature Date 11/28/2016 Subscriber Signature Date 11/28/2016 Subscriber Signature Date 11/28/2016 Subscriber Signature Date 11/28/2016 Subscriber Signature Date 11/28/2016 Subscriber Signature Subscriber Signature 12/28/2016 Subscriber Signature Date 11/28/2016 Subscriber Signature 14/28 Replacement of Prosthesis 44. Date of Prior Placement (MM/IDD/CCYY)  46. Date of Accident (MM/IDD/CCYY) 47. Auto Accident State 14/28. Replacement of Prosthesis 44. Date of Prior Placement (MM/IDD/CCYY)  47. Auto Accident State 14/28. Replacement of Prosthesis 44. Date of Prior Placement (MM/IDD/CCYY)  48. NPI 1790716421 Subscriber Signature 14/28. Replacement of Prosthe	1 2 3 4 5 6 7 8 9 10 11 12 1	3 14 15 16 34a.	Diagnosis Co	ode(s)	Α		C		Fee(s)	
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, or loss that by our 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  Subscriber 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  11/28/2016  Subscriber Signature Date  11/28/2016  Subscriber Signature Date  11/28/2016  Subscriber Signature Date  Ale Date of Protesthesis (MM/IDD/CCYY)  45. Treatment Resulting from Occupational illness/injury Auto accident Other accident (MM/IDD/CCYY)  46. Date of Accident (MM/IDD/CCYY)  47. Auto Accident State  TREATING DENTIST AND TREATMENT LOCATION INFORMATION  153. Interest went to provide a department of the patient or insured/subscriber.)  548. Name, Address, City, State, Zip Code  Kenneth M. Sadler, DDS and Associates, PA  201 Charlois Boulevard  Winston-Salem, NC 27103  50. License Number  51. SSN or TIN  56. 2132966  ANCILLARY CLAIM/TREATMENT INFORMATION  38. Place of Treatment 1 1 1 (e., 11=cfree; 22=c0P Hospital) (Use *Place of Service Codes for Professional Claims*)  39. Enclosures (Y or N)  41. Date Applicance Placed (MM/IDD/CCYY)  42. In Treatment for Orthodontics?  42. In Treatment (for Orthodontics?  43. Replacement of Prosthesis  14. Date Applicance Placed (MM/IDD/CCYY)  44. Date of Accident (MM/IDD/CCYY)  45. Treatment Resulting from  Coccupational illness/injury  Auto accident  Ancillary (Claim	32 31 30 29 28 27 26 25 24 23 22 21 2	) 19 18 17 (Prim	nary diagnosi	is in " <b>A</b> ")	в		D		32. Total Fee	275.00
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 dentits or dental practice has a contractual agreement with my plan prohibiting and 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 cannot cultivate in connection with this claim.  X SIGNATURE ON FILE 11/28/2016 Patient/Guardian Signature Date Date 11/28/2016 Subscriber Signature Date 11/28/2016 Subscriber Signature Date 11/28/2016 BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  BILLING 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 Slo	35. Remarks	<u>'</u>								
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Is well a 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 11/28/2016  73. 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 11/28/2016  Subscriber Signature Date 11/28/2016  Subscriber Signature Date 11/28/2016  Subscriber Signature Date 11/28/2016  Subscriber Signature Date 11/28/2016  Subscriber Signature Date Military (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  **SIGNATURE ON FILE 11/28/2016 Subscriber Signature Date 11/28/2016 Subscriber Signature Date 11/28/2016  **SUBSCRIPTION OF DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  **TREATING DENTIST AND TREATMENT LOCATION INFORMATION OF CORRUPTION OF CORR				. Place of Treatm	ent	11 (e.g. 11	=office; 22=O/P Ho	spital) 39. Er	nclosures (Y or N)	
At the patient of the patient of the dental benefits of the patient or insured/subscriber.)  SIGNATURE ON FILE  11/28/2016  73. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentits or dental entity.  X SIGNATURE ON FILE  11/28/2016  Subscriber Signature  Date  11/28/2016  Subscriber Signature  Date  11/28/2016  Subscriber Signature  Date  11/28/2016  Subscriber Signature  Date  46. Date of Accident (MM/DD/CCYY)  47. Auto Accident State  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  49. NPI  1144309410  50. License Number  51. SSN or TIN  1144309410  40. Is Ireatment for Orthodontics?  At No. (Skip 41-42)  No. (	law, or the treating dentist or dental practice has a contractual agr	eement with my plan prohib	iting all	(Use "Place of	of Servi	ce Codes for P	rofessional Claims")			
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  BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  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  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 56a, Provider Specialty Code 1223X0400X  201 Charlois Blvd Winston-Salem, NC 27103				. Is Treatment for	r Ortho	dontics?		41. Date	Appliance Placed	(MM/DD/CCYY)
Patient/Guardian Signature Date  42. Months of Treatment 14. Mon Yes (Complete 44)  43. Replacement of Prosthesis 14. Date of Prior Placement (MM/DD/CCYY)  45. Treatment Resulting from Occupational illness/injury Auto accident Other accident (MM/DD/CCYY)  46. Date of Accident (MM/DD/CCYY)  47. Auto Accident State  48. Name, Address, City, State, Zip Code  Kenneth M. Sadler, DDS and Associates, PA 201 Charlois Boulevard Winston-Salem, NC 27103  49. NPI 1144309410  41. Date of Prior Placement (MM/DD/CCYY)  42. Months of Treatment 43. Replacement of Prosthesis 44. Date of Prior Placement (MM/DD/CCYY)  44. Date of Prior Placement (MM/DD/CCYY)  45. Treatment Resulting from Occupational illness/injury Auto accident Other accident (MM/DD/CCYY)  47. Auto Accident State  48. Name, Address, City, State, Zip Code  Kenneth M. Sadler, DDS and Associates, PA 201 Charlois Boulevard  Winston-Salem, NC 27103  49. NPI 1144309410  4151  42. Months of Treatment 43. Replacement of Prosthesis 44. Date of Prior Placement (MM/DD/CCYY)  45. Treatment Resulting from Occupational illness/injury Auto accident  Cocupational illness/injury Auto accident  Auto Accident (MM/DD/CCYY)  47. Auto Accident State  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  49. NPI 1790716421  55. License Number  56. Address, City, State, Zip Code  Specially Code  1223X0400X  201 Charlois Blvd  Winston-Salem, NC 27103	l.			No (Skip	0 41-42	2) X Yes	(Complete 41-42)	8/17/2	2016	
**X** SIGNATURE ON FILE 11/28/2016  **Subscriber Signature Date Date Date Date Date Date Date Dat	' '	Date	42.	. Months of Treat	tment	43. Repla	cement of Prosthe	esis 44. Date	of Prior Placemen	nt (MM/DD/CCYY)
to the below named dentist or dental entity.  X SIGNATURE ON FILE 11/28/2016 Subscriber Signature Date 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  45. Treatment Resulting from  Occupational illness/injury Auto accident Other accident 46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State  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  49. NPI 1790716421 50. License Number 4151  51. SSN or TIN Vinston-Salem, NC 27103	37. I hereby authorize and direct payment of the dental benefits of	erwise pavable to me. dire	ectly	14		No	Yes (Complete	44)		
SIGNATURE ON FILE 11726/2016 Subscriber Signature Date 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 1790716421 55. License Number 4151 50. License Number 51. SSN or TIN 1144309410 4151 56-2132966  46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State 46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State 47. Auto Accide		or mos payable to me, and		. Treatment Resu	ulting fr	om				
Subscriber Signature  Date  46. Date of Accident (MM/DD/CCYY)  47. Auto Accident State  48. Name, Address, City, State, Zip Code  Kenneth M. Sadler, DDS and Associates, PA 201 Charlois Boulevard Winston-Salem, NC 27103  49. NPI 1144309410  41. Date of Accident (MM/DD/CCYY)  48. Date of Accident (MM/DD/CCYY)  48. Date of Accident (MM/DD/CCYY)  48. Date of Accident (MM/DD/CCYY)  49. Date  46. Date of Accident (MM/DD/CCYY)  47. Auto Accident State  47. Auto Accident State  47. Auto Accident State  48. Date of Accident (MM/DD/CCYY)  47. Auto Accident State  48. Date of Accident (MM/DD/CCYY)  47. Auto Accident State  48. Date of Accident (MM/DD/CCYY)  51. Incress of Accident (MM/DD/CCYY)  52. Incress as indicated by date are in progress (for procedures that require multiple visits) or have been completed.  48. Name, Address, City, State, Zip Code  Signed (Treating Dentist)  Date  54. NPI 1790716421  55. License Number  56. Address, City, State, Zip Code  Specialty Code  1223X0400X  201 Charlois Blvd Winston-Salem, NC 27103	X SIGNATURE ON FILE	11/28/2016		Occupat	ional ill	ness/injury	Auto a	ccident	Other accider	nt
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  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 56a. Provider Specialty Code 1223X0400X  49. NPI 144309410 50. License Number 51. SSN or TIN 56-2132966  50. License Number 51. SSN or TIN 56-2132966		46.	. Date of Acciden	nt (MM/	DD/CCYY)			47. Auto Accide	ent State	
11/28/2016     11/28/2016     201 Charlois Boulevard   Winston-Salem, NC 27103     201 Charlois Boulevard   Winston-Salem, NC 27103     201 Charlois Boulevard   Winston-Salem, NC 27103     201 Charlois Boulevard   201 Charlois Blvd   201 Charlois Bl		ot TR	REATING DEN	NTIST	AND TRE	ATMENT LOC	ATION INF	ORMATION		
Kenneth M. Sadler, DDS and Associates, PA 201 Charlois Boulevard Winston-Salem, NC 27103  **Tor. Martin Slominski**  **Signed (Treating Dentist)**  **Dr. Martin Slominski**  **Signed (Treating Dentist)**  **Dotation**  **Signed (Treating Dentist)**  **Signed (Treating Dentist)**  **Date**  **Signed (Treating Dentist)**  **Signed (Treating	submitting claim on behalf of the patient or insured/subscriber.)	ubmitting claim on behalf of the patient or insured/subscriber.)							ress (for procedure	es that require
201 Charlois Boulevard Winston-Salem, NC 27103  **Signed (Treating Dentist)**  **Signed (Trea	48. Name, Address, City, State, Zip Code			multiple visits)	or have	been comple	eted.			
201 Charlois Boulevard Winston-Salem, NC 27103  Signed (Treating Dentist)  54. NPI 1790716421  55. License Number  56. Address, City, State, Zip Code  56a. Provider Specialty Code 1223X0400X  49. NPI  1144309410  50. License Number  4151  51. SSN or TIN  56-2132966  201 Charlois Blvd Winston-Salem, NC 27103			Dr. Martin	Slo	minski			11/28/2016		
54. NPI   1790716421   55. License Number   56. Address, City, State, Zip Code   56a. Provider   Specialty Code   1223X0400X										
49. NPI         50. License Number         51. SSN or TIN         201 Charlois Blvd Winston-Salem, NC 27103         56a. Provider Specialty Code 1223X0400X	williston-Salem, INC 27 TUS		54.	. NPI 17907	1642	21	I .			
49. NPI       50. License Number       51. SSN or TIN       201 Charlois Blvd         1144309410       4151       56-2132966       Winston-Salem, NC 27103							56a Sn	a. Provider ecialty Code	1223X0400X	
1144303410	49. NPI 50. License Number	51. SSN or TIN					[39	, 2340		
52. Phone Number (336) 331-3500   52a. Additional Provider ID   57. Phone Number (336) 331-3500   58. Additional Provider ID   903HC	l		Wi	inston-Salem, N	NC 27	103				
	52. Phone Number (336) 331-3500   52a. Addition Provide	nal er ID	57.	Phone (33	6) 33	1-3500	58.	Additional Provider ID	903HC	

ADA American Dental Association <sup>®</sup> L	Jentai Ciaim	Form							
HEADER INFORMATION									
Type of Transaction (Mark all applicable boxes)									
X Statement of Actual Services Request for Predete	ermination/Preauthorization	ո							
X EPSDT / Title XIX									
2. Predetermination/Preauthorization Number		Ī	POLICYHOLI	DER/S	UBSCRIB	ER INFORMAT	ION (For Insur	ance Company N	lamed in #3)
		1	12. Policyholder	/Subsc	riber Name (	Last, First, Middle	Initial, Suffix), A	ddress, City, Sta	ite, Zip Code
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFO	ORMATION		CONNOD	C 14	MEC				
3. Company/Plan Name, Address, City, State, Zip Code			CONNOR						
BLUE CROSS BLUE SHIELD OF NC			CLEMMO			0 0 4 4 0			
P O BOX 2100			CLEIVIIVIOI	INO, I	NC 27012	2-0442			
WINSTON-SALEM, NC 27102		1	13. Date of Birth	(MM/E	DD/CCYY)	14. Gender	15. Policyho	Ider/Subscriber I	D (SSN or ID#)
			11/25/196	32		XMF	W13694	291	
OTHER COVERAGE (Mark applicable box and complete items 5	i-11. If none, leave blank.)	1	16. Plan/Group I	Numbe	er '	7. Employer Nam	e		
4. Dental? Medical? (If both, complete 5-11	for dental only.)		080960		F	RAI			
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, S	Suffix)	1	PATIENT INF	ORM	ATION				
		1	18. Relationship	to Poli	icyholder/Sul	scriber in #12 Ab	ove		ed For Future
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyho	Ider/Subscriber ID (SSN o	r ID#)	Self	Sp	pouse X	Dependent Child	Other	Use	
		2	20. Name (Last,	First, I	Middle Initial,	Suffix), Address,	City, State, Zip	Code	
9. Plan/Group Number 10. Patient's Relationship to P	erson named in #5		CONNOR	S. RY	YAN P				
Self Spouse	Dependent Othe	er	8100 LAS						
11. Other Insurance Company/Dental Benefit Plan Name, Address, C	City, State, Zip Code		CLEMMOI			-8442			
		2	21. Date of Birth	(MM/E	DD/CCYY)	22. Gender	23. Patient II	D/Account # (Ass	igned by Dentist)
			01/16/200	)2		X M _ F	8051371	62887	
RECORD OF SERVICES PROVIDED		•							
24. Procedure Date 25. Area 26. 27. Tooth Number	(s) 28. Tooth	29. Procedure	e 29a. Diag.	29b.		20.5			04.5
(MM/DD/CCYY) of Oral Tooth Cavity System or Letter(s)	Surface	Code	Pointer	Qty.		30. De	escription		31. Fee
1 11/28/2016		08670			PERIOD	ORTHO TX I	NSTALLME	NT	239.50
2									
3									
4									
5									
6									
7									
8									
9									
10									
33. Missing Teeth Information (Place an "X" on each missing tooth.)	34. Di	agnosis Cod	le List Qualifier		( ICD-9 =	B; ICD-10 = AB )		31a. Other	
1 2 3 4 5 6 7 8 9 10 11 12 13	14 15 16 34a. D	Diagnosis Co	ode(s)	A		c		Fee(s)	
32 31 30 29 28 27 26 25 24 23 22 21 20	19 18 17 (Prima	ary diagnosis	s in " <b>A</b> ")	В		D		32. Total Fee	239.50
35. Remarks	<u> </u>								
AUTHORIZATIONS		AN	ICILLARY CL	AIM/	TREATME	NT INFORMAT	ION		
36. I have been informed of the treatment plan and associated fees. I			Place of Treatm	ent -	11 (e.g. 11	=office; 22=O/P Hos	spital) 39. End	closures (Y or N)	
charges for dental services and materials not paid by my dental be law, or the treating dentist or dental practice has a contractual agre	ement with my plan prohibit	ting all	(Use "Place of	of Servi	ce Codes for P	rofessional Claims")			
or a portion of such charges. To the extent permitted by law, I cons of my protected health information to carry out payment activities i			Is Treatment for	r Ortho	dontics?		41. Date	Appliance Placed	(MM/DD/CCYY)
X SIGNATURE ON FILE	11/28/2016		No (Ski	p 41-42	2) X Yes	(Complete 41-42)	8/19/2	016	
Patient/Guardian Signature	Date	42.	Months of Treat	tment	43. Repla	cement of Prosthe	sis 44. Date	of Prior Placemer	nt (MM/DD/CCYY)
37. I hereby authorize and direct payment of the dental benefits other	rwise pavable to me. direc	tlv	16		No	Yes (Complete	44)		
to the below named dentist or dental entity.	payasse to, a		Treatment Resu	ulting fr	rom				
X SIGNATURE ON FILE	11/28/2016		Occupat	tional ill	lness/injury	Auto a	ccident	Other accide	nt
Subscriber Signature	46.	Date of Accider	nt (MM/	/DD/CCYY)			47. Auto Accide	ent State	
BILLING DENTIST OR DENTAL ENTITY (Leave blank if de	TR	REATING DEN	NTIST	AND TRE	ATMENT LOC	ATION INFO	RMATION		
submitting claim on behalf of the patient or insured/subscriber.)	53.	I hereby certify	that the	e procedures	as indicated by d	ate are in progr	ess (for procedur	es that require	
48. Name, Address, City, State, Zip Code	8. Name, Address, City, State, Zip Code								
Kenneth M. Sadler, DDS and Associates, PA								11/28/2016	
201 Charlois Boulevard								Date	
Winston-Salem, NC 27103		54.	NPI 17907	1642	<u> </u>	55.	License Numbe	er	
			Address, City, S			56a	a. Provider ecialty Code 1	223X0400X	,
49. NPI 50. License Number	51. SSN or TIN		1 Charlois Blvd			[ 35	, 0040 1		
1144309410 4151	56-2132966	Wir	nston-Salem, I	NC 27	103				
52. Phone Number (336) 331-3500 52a. Addition Provider	al · ID	57.	Phone Number (33	6) 33	1-3500	58.	Additional 9 Provider ID 9	03HC	

ADA American Dent	ai Assoc	liation" <b>Dent</b>	ai Ciain	1 Forr	n								
HEADER INFORMATION													
Type of Transaction (Mark all applied)	cable boxes)				ı								
X Statement of Actual Services	Re	quest for Predetermination	n/Preauthoriza	tion									
X EPSDT / Title XIX					L								
2. Predetermination/Preauthorization	Number				P	OLICYHOL	DER/S	UBSCRIB	ER INFORMA	TION (Fo	r Insurance	e Company N	amed in #3)
					12	2. Policyholder	/Subsc	riber Name (	Last, First, Middl	le Initial, Su	uffix), Addre	ess, City, Sta	te, Zip Code
INSURANCE COMPANY/DEN	TAL BENEF	T PLAN INFORMAT	ION		ן ∟	CULLER,	DER	ORAH F					
3. Company/Plan Name, Address, Ci	ty, State, Zip C	ode				324 FARM							
BLUE CROSS BLUE SH	HELD OF N	VC				MOUNT A		-	30-5748				
P O BOX 2100	07400				$\perp$								
WINSTON-SALEM, NC	2/102				13	<ol><li>Date of Birth</li></ol>	(MM/E	DD/CCYY)	14. Gender		olicyholder/	/Subscriber II	O (SSN or ID#)
					┸	01/21/196	35		M X	F   W13	369468	5	
OTHER COVERAGE (Mark appli	cable box and	complete items 5-11. If n	one, leave blan	k.)	-	6. Plan/Group	Numbe		17. Employer Na	me			
4. Dental? Medical?	(If bot	h, complete 5-11 for dent	al only.)		┸	080960		F	RAI				
5. Name of Policyholder/Subscriber i	n #4 (Last, Firs	t, Middle Initial, Suffix)			P	ATIENT INF	ORM	ATION					
					18			_	oscriber in #12 A			19. Reserve	ed For Future
6. Date of Birth (MM/DD/CCYY)	7. Gender	8. Policyholder/Sub	scriber ID (SSN	l or ID#)	$\vdash$	Self	<u> </u>	oouse X	Dependent Chil		her		
	м				20	0. Name (Last,	First, N	Middle Initial,	Suffix), Address	, City, State	e, Zip Code	Э	
9. Plan/Group Number		Relationship to Person na				CULLER,							
	Self			ther	_	324 FARM							
11. Other Insurance Company/Denta	I Benefit Plan N	lame, Address, City, Stat	e, Zip Code			MOUNT A	JIRY,	NC 2703	0-5/48				
					4 D-tf Di-tl-	/A AB A/E	200000	00.0	00 P	-t:t ID/A -			
			<ol> <li>Date of Birth</li> <li>01/07/200</li> </ol>	-	JD/CCYY)	22. Gender		121162	•	gned by Dentist)			
				_	01/07/200					121102	000		
RECORD OF SERVICES PRO								Г					
24. Procedure Date of Ora (MM/DD/CCYY)	I Tooth	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Proce Code		29a. Diag. Pointer	29b. Qty.		30. [	Description			31. Fee
1 11/28/2016	System			D8670				PERIOD	ORTHO TX	INSTAL	IMENT		266.11
2								LINIOD	OKITIO IX	III O I / L	LIVILIAI		200.11
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33. Missing Teeth Information (Place	an "X" on each	missing tooth.)	34.	Diagnosis (	Code	List Qualifier		( ICD-9 =	B; ICD-10 = AB	)	31	1a. Other	
1 2 3 4 5 6 7	8 9 10	11 12 13 14		a. Diagnosis			<u>——</u> А		С	,		Fee(s)	
32 31 30 29 28 27 26	25 24 23	3 22 21 20 19	18 17 (Pri	imary diagn	osis	in " <b>A</b> ")	В		D		32	2. Total Fee	266.11
35. Remarks													
AUTHORIZATIONS					ANC	CILLARY CI	AIM/	TREATME	NT INFORMA	TION			
<ol> <li>I have been informed of the treatn charges for dental services and m</li> </ol>					38. F	Place of Treatm			=office; 22=O/P H		39. Enclosu	ures (Y or N)	
law, or the treating dentist or denta	I practice has a	contractual agreement w	ith my plan proh	ibiting all		(Use "Place	of Service	ce Codes for P	rofessional Claims	")			
or a portion of such charges. To the of my protected health information					40. Is	s Treatment fo					. Date Appl	iance Placed	(MM/DD/CCYY)
X SIGNATURE ON	FILE	11	/28/2016			No (Ski)		2) X Yes	(Complete 41-42		/13/2016		
Patient/Guardian Signature		Da	te	I	42. N	Months of Trea	tment	I — ' -	cement of Prosth		. Date of Pr	rior Placemen	t (MM/DD/CCYY)
37. I hereby authorize and direct pay		ntal benefits otherwise pa	yable to me, di			12		No	Yes (Complet	te 44)			
to the below named dentist or de	ntal entity.				45. T	reatment Res	-						
X SIGNATURE ON	FILE		/28/2016			<u> </u>		ness/injury	Auto	accident		Other accider	
	Subscriber Signature Date							DD/CCYY)				. Auto Accide	nt 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.)								ATMENT LO				
								e procedures been compl	as indicated by eted.	date are in	n progress (	(for procedure	es that require
48. Name, Address, City, State, Zip C		. DA			-	,							
Kenneth M. Sadler, DDS and 201 Charlois Boulevard	ASSOCIATES	o, ra			$X_{-}$	Dr. Martin					11/	28/2016	
Winston-Salem, NC 27103				-	54 1	Signed (Trea			-	5. License I	Number	Date	
						NPI 17907 Address, City, 8						2)/0/2001	
40 NDI	License North	54 001	or TIM					ih code	Š	pecialty Co	ode 1223	3X0400X	
I I	. License Numb 51	per 51. SSN 56-213				Charlois Blvo ston-Salem, I		103					
52. Phone (226) 221 2500		52a. Additional			57. F	Phone (22			58	3. Additiona	al ooci	LIC.	
<sup>32. Phone</sup> Number (336) 331-3500		Provider ID			N	Number (33	0) 33	1-3500		Provider	<sup>al</sup> 903I	пС	

ADA American Dentai A	Association <sup>®</sup> <b>Dent</b>	ai Ciaim	Form							
HEADER INFORMATION										
1. Type of Transaction (Mark all applicable	e boxes)									
X Statement of Actual Services	Request for Predetermination	n/Preauthorization	on							
X EPSDT / Title XIX										
2. Predetermination/Preauthorization Numb	ber			POLICYHOLI	DER/S	UBSCRIB	ER INFORMAT	ION (For Insura	ance Company N	lamed in #3)
				12. Policyholder	/Subsc	riber Name (	Last, First, Middle	Initial, Suffix), A	ddress, City, Sta	ite, Zip Code
INSURANCE COMPANY/DENTAL	BENEFIT PLAN INFORMAT	ION		HAUSER,	CDE	COPV				
3. Company/Plan Name, Address, City, Sta	ate, Zip Code			521 DODS			۸Π			
BLUE CROSS BLUE SHIELI	D OF NC			PILOT MC	_	_				
P O BOX 2100				FILOT WIC	JUNI	Ally, IVC	27041			
WINSTON-SALEM, NC 2710	02			13. Date of Birth	(MM/E	DD/CCYY)	14. Gender	15. Policyhol	lder/Subscriber I	D (SSN or ID#)
				11/20/195	2		X M F	W13690	898	
OTHER COVERAGE (Mark applicable	box and complete items 5-11. If no	one, leave blank.	.)	16. Plan/Group i	Numbe	r 1	7. Employer Nam	e		
4. Dental? Medical?	(If both, complete 5-11 for denta	al only.)		080960		F	RAI			
5. Name of Policyholder/Subscriber in #4 (	(Last, First, Middle Initial, Suffix)		Ī	PATIENT INF	ORM	ATION				
			ŀ	18. Relationship	to Poli	icyholder/Sub	scriber in #12 Abo	ove	19. Reserv	ed For Future
6. Date of Birth (MM/DD/CCYY) 7. Ge	Sender 8. Policyholder/Subs	scriber ID (SSN	or ID#)	Self	Sp	oouse X	Dependent Child	Other	Use	
	M F	,	· · · · ·	20. Name (Last,	First, N	Middle Initial,	Suffix), Address,	City, State, Zip (	Code	
9. Plan/Group Number 10. P	Patient's Relationship to Person na	med in #5		HAUSER,	СНА	RI OTTE	ANN			
	Self Spouse Depe	ndent Oth	ner	521 DODS						
11. Other Insurance Company/Dental Bene	efit Plan Name, Address, City, State	e, Zip Code		PILOT MC	_					
						•				
			ľ	21. Date of Birth	(MM/E	DD/CCYY)	22. Gender	23. Patient II	D/Account # (Ass	igned by Dentist)
				05/04/200	)5		M X F	8051251	62885	
RECORD OF SERVICES PROVIDE	:D									
24 Procedure Date 25. Area 26	6. 27 Tooth Number(s)	28. Tooth	29. Procedur	re 29a. Diag.	29b.					
(MM/DD/CCYY) of Oral Too Cavity Syste	Ott   or Letter(s)	Surface	Code	Pointer	Qty.		30. De	escription		31. Fee
1 11/28/2016			D8670			PERIOD	ORTHO TX I	NSTALLME	NT	197.33
2										
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10										
33. Missing Teeth Information (Place an "X"	(" on each missing tooth )	34 [	Diagnosis Cod	de List Qualifier		(ICD-9 =	B; ICD-10 = AB )		31a. Other	
1 2 3 4 5 6 7 8	9 10 11 12 13 14 1		Diagnosis Co		<u> </u>	(100-3 =	C		Fee(s)	
32 31 30 29 28 27 26 25			nary diagnos	:- :- «A»\	A				32. Total Fee	107.22
35. Remarks	24 25 22 21 20 19 10	0 17 (11111	nary diagnos	ois iii A )	В		D		02. TOTAL T CC	197.33
33. Remarks										
AUTHORIZATIONS			LAI	NCILL ARY CI	AIM/	TDEATME	NT INFORMAT	ION		
36. I have been informed of the treatment pl	plan and associated fees. Lagree to I	be responsible fo	-	B. Place of Treatm			=office; 22=O/P Hos		losures (Y or N)	
charges for dental services and material	als not paid by my dental benefit plar	n, unless prohibit	ed by				rofessional Claims")			
law, or the treating dentist or dental pract or a portion of such charges. To the exte	ent permitted by law, I consent to yo	ur use and disclo	osure 40	). Is Treatment for	r Ortho	dontics?		// Date /	Annliance Placed	I (MM/DD/CCYY)
of my protected health information to car			m.   40	No (Skir			(Complete 41-42)			(WIWI/DD/CCTT)
X SIGNATURE ON FILE Patient/Guardian Signature	E 11/	/28/2016		2. Months of Treat			cement of Prosthe	6/30/20		nt (MM/DD/CCYY)
				25	uneni	No No	Yes (Complete		oi Piloi Piacemer	it (iviivi/DD/CC++)
<ol> <li>I hereby authorize and direct payment of to the below named dentist or dental en</li> </ol>		yable to me, dire		. Treatment Resu	ultina fr		Tes (Complete	44)		
			45		-	ness/injury	☐ Auto o	ccident [	Other accide	nt
X SIGNATURE ON FILE	.E 11,	/28/2016	— <u> </u>				Auto at	Codeni		
Subscriber Signature	_	6. Date of Acciden					47. Auto Accide	ent 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.)						ATMENT LOC			
			53	<ol> <li>I hereby certify multiple visits) or</li> </ol>			as indicated by detect	ate are in progre	ess (for procedur	es that require
48. Name, Address, City, State, Zip Code	anniatan DA			a.apio violoj (	vc	. Soon compli				
Kenneth M. Sadler, DDS and Ass 201 Charlois Boulevard	sociates, PA		>	CDr. Martin				•	11/28/2016	
Winston-Salem, NC 27103									Date	
,				NPI 17907				License Numbe		
				S. Address, City, S		ip Code	Spe	ecialty Code 12	223X0400X	
l I	nse Number 51. SSN 6			01 Charlois Blvd inston-Salem, N		103				
1144309410 4151	56-213	2966		Dhono			1.50	Additional		
<sup>52.</sup> Phone Number (336) 331-3500	52a. Additional Provider ID		57	'. Phone Number (33	6) 33	1-3500	58.	Additional 90 Provider ID	03HC	

ADA American Dental Association Denta	ai Ciaim	Form							
HEADER INFORMATION									
Type of Transaction (Mark all applicable boxes)									
X Statement of Actual Services Request for Predetermination	n/Preauthorization	n							
X EPSDT / Title XIX									
2. Predetermination/Preauthorization Number			POLICYHOLI	DER/S	UBSCRIB	ER INFORMAT	ION (For Insu	ance Company N	Named in #3)
			12. Policyholder	/Subsc	riber Name (	Last, First, Middle	Initial, Suffix),	Address, City, Sta	ite, Zip Code
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATI	ON		CTELIMA	NI T	IMACTUV				
3. Company/Plan Name, Address, City, State, Zip Code			STEELMA 272 SADD	,					
BLUE CROSS BLUE SHIELD OF NC			WINSTON	_					
P O BOX 2100			WINSTON	I-SAL	LEIVI, INC	27 107			
WINSTON-SALEM, NC 27102			13. Date of Birth	(MM/E	DD/CCYY)	14. Gender	15. Policyho	lder/Subscriber I	D (SSN or ID#)
			04/26/197	6		X M D F	W13695	421	
OTHER COVERAGE (Mark applicable box and complete items 5-11. If no	ne, leave blank.)	)	16. Plan/Group N	Numbe	er 1	7. Employer Nan	ne		
4. Dental? Medical? (If both, complete 5-11 for denta	l only.)		080960		F	RAI			
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)			PATIENT INF	ORM	ATION				
		T-	18. Relationship	to Poli	icyholder/Suk	scriber in #12 Ab	ove	19. Reserv	ed For Future
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subs	criber ID (SSN o	or ID#)	Self	Sp	pouse X	Dependent Child	Other	Use	
	,	·	20. Name (Last,	First, I	Middle Initial,	Suffix), Address,	City, State, Zip	Code	
Plan/Group Number     10. Patient's Relationship to Person name	ned in #5		STEELMA	N. JA	ACFY				
Self Spouse Deper	ndent Othe	er	272 SADD						
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State	, Zip Code		WINSTON						
			21. Date of Birth	(MM/E	DD/CCYY)	22. Gender	23. Patient I	D/Account # (Ass	igned by Dentist)
			11/11/200	4		M X F	8051281	62884	
RECORD OF SERVICES PROVIDED									
24. Procedure Date 25. Area 26. 27. Tooth Number(s)	28. Tooth	29. Procedure	e 29a. Diag.	29b.		20.5			04.5
(MM/DD/CCYY) of Oral Tooth or Letter(s)	Surface	Code	Pointer	Qty.		30. D	escription		31. Fee
1 11/28/2016	1	D8670			PERIOD	ORTHO TX	INSTALLME	:NT	199.58
2									
3									
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9									
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33. Missing Teeth Information (Place an "X" on each missing tooth.)	34. Di	iagnosis Cod	de List Qualifier		(ICD-9 =	B; ICD-10 = AB )		31a. Other	
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15		Diagnosis Co			(	С		Fee(s)	
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18	3 17 (Prima	ary diagnosi	is in "A")	^ В				32. Total Fee	199.58
35. Remarks		, ,	<u> </u>	<u> </u>					100.00
AUTHORIZATIONS		I AN	NCILLARY CL	AIM/	TREATME	NT INFORMAT	TION		
36. I have been informed of the treatment plan and associated fees. I agree to be	e responsible for		. Place of Treatm			=office; 22=O/P Ho		closures (Y or N)	
charges for dental services and materials not paid by my dental benefit plan law, or the treating dentist or dental practice has a contractual agreement with			(Use "Place of	of Servi	ce Codes for P	rofessional Claims"			
or a portion of such charges. To the extent permitted by law, I consent to you	ur use and disclos	sure 40	. Is Treatment for	r Ortho	dontics?		41. Date	Appliance Placed	d (MM/DD/CCYY)
of my protected health information to carry out payment activities in connect  X SIGNATURE ON FILE 11/1.	ion with this clain 28/2016	n.	No (Skip	41-42	2) X Yes	(Complete 41-42)	6/9/20	16	,
X SIGNATURE ON FILE 11/. Patient/Guardian Signature Date		— <del> </del> 42.	. Months of Treat			cement of Prosthe	0,0,20		nt (MM/DD/CCYY)
			23		□ No □	Yes (Complete			,
<ol> <li>I hereby authorize and direct payment of the dental benefits otherwise pay to the below named dentist or dental entity.</li> </ol>	able to me, direc		. Treatment Resu	ulting fr	rom				
CIONATUDE ON EU E	29/2016			-	Iness/injury	Auto a	ccident	Other accide	nt
X SIGNATURE ON FILE 11/1/ Subscriber Signature Date								47. Auto Accide	ent State
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or d	_	. Date of Acciden	•		ATMENT LOC	ATION INEC		on otato	
submitting claim on behalf of the patient or insured/subscriber.)					as indicated by			es that require	
48 Name Address City State 7in Code	8. Name, Address, City, State, Zip Code							ess (for procedur	es trat require
Kenneth M. Sadler, DDS and Associates, PA			Dr. Martin	CI.	noin ele!			44/00/0040	
201 Charlois Boulevard	01 Charlois Boulevard							11/28/2016 Date	
Winston-Salem, NC 27103		54	Signed (Treat			55	License Numb		
			. Address, City, S						,
49. NPI 50. License Number 51. SSN c	or TIN		1 Charlois Blvd		.ip Gode	Sp	ecialty Code 1	223X0400X	<u> </u>
49. NPI 50. License Number 51. SSN c 1144309410 4151 56-2132			inston-Salem, N		103				
52. Phone (236) 231 2500   52a. Additional	-000	57.	Phone (22			158	Additional	02110	
Number (336) 331-3500 Sza. Additional Provider ID			Number (33	0) 33	1-3500		Additional Provider ID	บงทษ	

ADA Ameri	can De	enta	ai As	SOCI	ation	Dent	ai Ciai	m For	m								
HEADER INFOR	MATION																
Type of Transaction	n (Mark all	applica	able box	xes)													
X Statement of A	Actual Servi	ces		Requ	est for Prede	terminatio	n/Preauthori	zation									
X EPSDT / Title >	XIX																
2. Predetermination/F	Preauthoriza	ation N	lumber						Р	OLICYHOL	DER/S	UBSCRIB	ER INFORMA	TION (	(For Insurar	nce Company N	lamed in #3)
									12	2. Policyholder	r/Subsci	riber Name (	Last, First, Midd	le Initial,	, Suffix), Ad	dress, City, Sta	ite, Zip Code
INSURANCE CO	MPANY/D	ENT	AL BE	NEFIT	PLAN IN	ORMAT	ION		Π.	KING OD		DV C					
3. Company/Plan Na	me, Addres	s, City	, State,	Zip Cod	le				- 1	KING, GR 2515 MO(							
BLUE CROS	S BLUE	SHI	ELD (	OF NO	2				- 1	ZS IS MOC HIGH POI		-	E				
P O BOX 210	00								- [ '	nigh POI	IIN I , I	NC 2720	3				
WINSTON-S	SALEM, N	NC 2	7102						13	3. Date of Birth	n (MM/E	DD/CCYY)	14. Gender	15.	. Policyhold	er/Subscriber I	D (SSN or ID#)
										12/04/196	33		$X^{M}$	F W	/136936	91	
OTHER COVERA	GE (Mark a	applica	able box	x and co	mplete items	5-11. If no	one, leave bl	ank.)	16	6. Plan/Group	Numbe	er '	17. Employer Na	me			
4. Dental?	Medical?			(If both,	complete 5-1	1 for denta	al only.)		Π.	080960		F	RAI				
5. Name of Policyholo	der/Subscril	ber in	#4 (Las	st, First,	Middle Initial	, Suffix)			P	ATIENT IN	FORM	ATION					
									18	8. Relationship	to Poli	icyholder/Sul	oscriber in #12 A	bove			ed For Future
6. Date of Birth (MM/	DD/CCYY)	7	7. Gend	ler	8. Policyh	older/Sub	scriber ID (S	SN or ID#)	1	Self	Sp	oouse X	Dependent Chi	ld 🗌	Other	Use	
			M	F					20	D. Name (Last,	, First, N	Middle Initial,	Suffix), Address	, City, S	State, Zip Co	ode	
9. Plan/Group Numbe	er	1	10. Pati	ent's Re	lationship to	Person na	med in #5		┨.	KING. BE	N S						
			Se	lf	Spouse	Depe	ndent	Other		2515 MO		DAD					
11. Other Insurance (	Company/D	ental E	Benefit I	Plan Naı	me, Address,	City, State	e, Zip Code		1	HIGH POI	INT, N	NC 27265	, )				
									21	1. Date of Birth	n (MM/E	DD/CCYY)	22. Gender	23.	. Patient ID/	Account # (Ass	igned by Dentist)
										08/05/200	)3		X M	F 80	)515816	2883	
RECORD OF SER	RVICES P	ROV	IDED														
24. Procedure		5. Area	26. Ta ette	2	7. Tooth Numb	er(s)	28. Tooth	29. Pro	edure	29a. Diag.	29b.		20.1	D = = ==i==#i=			24 5
(MM/DD/CCY		of Oral Cavity	Tooth System		or Letter(s)		Surface	Cod	de	Pointer	Qty.		30.1	Description	on		31. Fee
1 11/28/2016								D867	)			PERIOD	ORTHO TX	INST	ALLMEN	IT	206.25
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33. Missing Teeth Info	rmation (Pl	lace a	n "X" on	each m	issing tooth.	)	3	4. Diagnosis	Code	List Qualifier		( ICD-9 =	B; ICD-10 = AB	)		31a. Other	
1 2 3 4	5 6	7	8 9	9 10	11 12 1	3 14 1	5 16 3	4a. Diagnos	is Cod	e(s)	Α		c			Fee(s)	
32 31 30 29	28 27	26	25 2	4 23	22 21 2	0 19 1	8 17 (	Primary dia	gnosis	in " <b>A</b> ")	в		D			32. Total Fee	206.25
35. Remarks																	
AUTHORIZATIO	NS								ANG	CILLARY CI	LAIM/1	TREATME	NT INFORMA	TION			
36. I have been inform charges for dental									38. F	Place of Treatm			=office; 22=O/P H		39. Enclo	sures (Y or N)	
law, or the treating	dentist or c	dental	practice	has a co	ontractual agr	eement wi	th my plan pr	ohibiting all		(Use "Place	of Service	ce Codes for P	rofessional Claims	5")			
or a portion of suc of my protected he									40. Is	s Treatment fo	r Ortho	dontics?			41. Date Ap	opliance Placed	(MM/DD/CCYY)
X SIGNA	ATURE (	ON F	ILE			11	/28/2016			No (Ski	p 41-42	2) X Yes	(Complete 41-42	2)	10/6/20	16	
Patient/Guardian	Signature					Dat	е		42. N	Months of Trea	tment	43. Repla	cement of Prosth	nesis	44. Date of	Prior Placemer	nt (MM/DD/CCYY)
37. I hereby authorize	e and direct	paym	ent of th	he denta	al benefits oth	erwise pa	yable to me,	directly	<u> </u>	22		No	Yes (Complet	te 44)			
to the below name								,	45. T	reatment Res	ulting fr	om					
X SIGNA	ATURE (	ON F	FILE			11	/28/2016			Occupa	tional ill	ness/injury	Auto	acciden	nt _	Other accide	nt
	Subscriber Signature Date							46. E	Date of Accide	nt (MM/	DD/CCYY)				47. Auto Accide	ent State	
	BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not						is not	TRE	ATING DE	NTIST	AND TRE	ATMENT LO	CATIO	N INFOR	MATION		
submitting claim on b	ubmitting claim on behalf of the patient or insured/subscriber.)												as indicated by	date are	e in progres	s (for procedur	es that require
48. Name, Address, 0		-							n	nultiple visits)	or have	been compl	eted.				
	Cenneth M. Sadler, DDS and Associates, PA							Ιx	Dr. Martin	n Sloi	minski			1	1/28/2016		
	ାୀ Charlois Boulevard inston-Salem, NC 27103							Ľ	Signed (Trea						Date		
vviiistori-Saleifi,	140 2/10	,,,							54. N	<sup>NPI</sup> 17907	1642	21			se Number		
									56. A	Address, City, S	State, Z	ip Code	5/ S	6a. Prov pecialty	rider Code 12	23X0400X	
49. NPI		1		Number	r	51. SSN				Charlois Blv		400	_				
1144309410		415	51			56-213	2966			ston-Salem,	NC 27	103					
52. Phone Number (336)	331-350	00			52a. Additio Provid	nal er ID			57. F	Phone Number (33	36) 33	1-3500	5	8. Addition Provide 18 18 18 18 18 18 18 18 18 18 18 18 18	onal der ID 90	3HC	

F	۱	<b>DA</b> American L	ent	al As	SOCI	ation®	Dent	ai Cia	aim Fo	orm								
	Н	EADER INFORMATION	1															
- 1	1.	Type of Transaction (Mark a	all applic	able bo	xes)													
- 1		X Statement of Actual Ser	rvices		Reque	est for Prede	terminatio	n/Preauth	orization									
- 1		X EPSDT / Title XIX																
- [7	2.	Predetermination/Preauthor	rization	Number							POLICYHOL	DER/S	UBSCRIB	ER INFORM	IATIO	<b>N</b> (For Insurar	nce Company N	Named in #3)
- 1											12. Policyholder	r/Subsc	riber Name (	(Last, First, Mid	ddle Init	tial, Suffix), Ad	dress, City, Sta	ite, Zip Code
Ī	IN	SURANCE COMPANY	/DENT	AL BE	NEFIT	PLAN INF	ORMAT	ION			SORRELL	CD	ECODY					
_ [	3.	Company/Plan Name, Addr	ess, Cit	y, State,	Zip Code	е					4280 VIKI							
- 1		BLUE CROSS BLU	JE SH	IELD	OF NO						WINSTON	_		27105				
- 1		P O BOX 2100								L	***************************************			27 100				
- 1		WINSTON-SALEM	, NC 2	27102							13. Date of Birth	n (MM/[	DD/CCYY)	14. Gender		<ol><li>Policyhold</li></ol>	er/Subscriber I	D (SSN or ID#)
L											09/07/196	32		XM	F	W164526	81	
	01	THER COVERAGE (Mar	k applic	able bo	x and cor	mplete items	5-11. If n	one, leave	blank.)		16. Plan/Group	Numbe		17. Employer N	Name			
Ŀ	4.	Dental? X Medica	al?		(If both, o	complete 5-1	1 for dent	al only.)			081501			BCBS				
- [		Name of Policyholder/Subs		#4 (Las	st, First, N	Middle Initial	Suffix)				PATIENT IN	FORM	ATION					
_		REGINA SORREL									18. Relationship		_	_	_	_	19. Reserv Use	ed For Future
<b>−</b> g		Date of Birth (MM/DD/CCY)	Y)	7. Gend		1 .		scriber ID	(SSN or ID	· -	Self			Dependent C		Other		
-	_	12/18/1970			XF	245467				:	20. Name (Last	, First, I	Middle Initial,	, Suffix), Addre	ss, City	, State, Zip Co	ode	
- [		Plan/Group Number				ationship to		_	_		SORRELL							
-		00003558	/Dest	Se			X Depe		Other		4280 VIKI			07405				
	11.	Other Insurance Company					City, Stat	e, ∠ip Cod	е		WINSTON	N SAL	_⊨M, NC	2/105				
- 1		INTERACTIVE ME PO BOX 1349	DICA	LSY	S I EIVI	5				- 1	21. Date of Birth	- /BABA/I	DICCVV)	22. Gender	1.	22 Patient ID	A account # /Acc	igned by Dentist)
- 1		WAKE FOREST, N	IC 27	588						<b>I</b>	06/20/200		JD/CCTT)	X M	_ I	23. Fallelli 15/ 80514116	•	igned by Dentist)
H	_										00/20/200			<u> </u>	<u> </u>	00014110	2002	
ŀ	RECORD OF SERVICES PROVIDED									Procedure	00- 8:	001						
- 1		24. Procedure Date (MM/DD/CCYY) 25. Area 26. of Oral Tooth Tooth or Letter(s) 28. Tooth Surface									e 29a. Diag. Pointer	29b. Qty.		30	0. Descri	iption		31. Fee
ı	1	11/28/2016					D86	670			PERIOD	ORTHO T	X INS	STALLMEN	IT	199.58		
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	33.	Missing Teeth Information	(Place a	an "X" or	n each mi	issing tooth.			34. Diagn	osis Cod	de List Qualifier		( ICD-9 =	B; ICD-10 = A	В)		31a. Other	
		1 2 3 4 5 6	6 7	8 9	9 10	11 12 1	3 14 1	5 16	34a. Diag	nosis Co	ode(s)	Α		c_			Fee(s)	
		32 31 30 29 28 2	7 26	25 2	4 23	22 21 2	) 19 1	18 17	(Primary	diagnosi	is in " <b>A</b> ")	В		D_			32. Total Fee	199.58
-gg [	35	. Remarks																
ŀ																		
- ⊢		JTHORIZATIONS				-:	1	h	-:h-1 fII	-	ICILLARY CI						O/ ND	
- [	30.	<ul> <li>I have been informed of the charges for dental services</li> </ul>	and ma	aterials n	ot paid by	y my dental l	enefit pla	n, unless p	rohibited by	/ <b> </b>	Place of Treatm	_		1=office; 22=O/F Professional Clai		a) 39. Encid	osures (Y or N)	
- 1		law, or the treating dentist of or a portion of such charge	s. To the	extent	permitted	l by law, I cor	sent to yo	our use and	disclosure	. —	. Is Treatment fo			Torosolorial oldi	,	11 Data A	nlianas Plasas	(MM/DD/CCYY)
		of my protected health info		-	out paym	ent activities				140.	No (Ski			(Complete 41-	42)	'	•	(IVIIVI/DD/CC++)
- [-	X	SIGNATURE Patient/Guardian Signature		FILE			11 Dat	/28/201	16	-	. Months of Trea			acement of Pro		8/19/20		nt (MM/DD/CCYY)
L											23	uneni	No No	_			r noi r lacemei	it (MINI/DD/CC11)
- [	37	<ul> <li>I hereby authorize and directors to the below named dentise</li> </ul>				l benefits oth	erwise pa	yable to m	ne, directly	45	. Treatment Res	ultina fi		100 (00111)	1010 44)	<u>′                                      </u>		
- [	,							16			-	Iness/injury	Au	to accid	lent -	Other accide	nt	
	X SIGNATURE ON FILE 11/28/2016 Subscriber Signature Date							10	- <del> </del> 46.	. Date of Accide	nt (MM	/DD/CCYY)				 47. Auto Accide	ent State	
h	BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not							tv is not	_	REATING DEI	,		EATMENT L	OCAT				
		bmitting claim on behalf of t							.,		I hereby certify							es that require
Į.	48	. Name, Address, City, State	e, Zip C	ode						$\dashv$	multiple visits)	or have	been compl	leted.	•			
		enneth M. Sadler, DD		Assoc	ciates, l	PA				_	Dr. Martin	. Slo	minski			1	1/28/2016	
		01 Charlois Boulevard								^	Signed (Trea					<u> </u>	Date	
	٧V	inston-Salem, NC 27	103							54.	NPI 17907	1642	21			ense Number		
										56.	Address, City, S	State, Z	Zip Code		56a. Pi Specia	rovider Ilty Code 12	23X0400X	,
		. NPI			Number		51. SSN				1 Charlois Blv		102					
		44309410	41	51		52a. Additio	56-213	2966			nston-Salem,	NC 27	103					
	52	Phone (336) 331-35		57.	Phone Number (33	36) 33	1-3500		58. Add	ditional ovider ID 90	3HC							

HIGHADER INFORMATION   Proposed Services   Properties of Art. and Employees (and the displayable schools)   Properties of Art. and Employees   Properties   Properties of Art. and Employees   Properties   Propert	ADA American Dental Association Dental	Claim	Form							
Separation   Decided   Decided   Production   Production (Company Named in 6)	HEADER INFORMATION									
POLICYHOLDERISUBSORIBER INFORMATION   The timescance Company Nerval in (8)	Type of Transaction (Mark all applicable boxes)									
Policy Project Designation Comment Number   Policy Project Designation	X Statement of Actual Services Request for Predetermination/P	reauthorization	1							
Polycologic Scanner   Fame   Carl   Prol. Micha Hulle, Sulfo, Address, Cty, State, Zp Code	X EPSDT / Title XIX									
Section   Company   Comp	2. Predetermination/Preauthorization Number		P	POLICYHOLI	DER/S	UBSCRIB	ER INFORM <i>A</i>	TION (For I	Insurance Company N	amed in #3)
Summary Plans Names, Address, 0th, Otable, Ze Code			1	12. Policyholder	/Subsci	riber Name (	Last, First, Midd	lle Initial, Suff	fix), Address, City, Stat	te, Zip Code
Some of Pethyl Management   Some	INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	N		CATEALL	CVDI	DINICTO	N DADDAI	<b>⊃</b> Λ		
BLUE CROSS BLUE SHIELD OF NO   VINSTON SALEM, NC 27106   10 Deer Glierh (MMODCOTY)   14. Gender   15. Policholdshrökbericker (P. (SSN of IDN) OR(271970)   15. Policholdshrökbericker (P. (SSN of IDN) OR(27190)   15. Policholdshrökbericker (P. (SSN	3. Company/Plan Name, Address, City, State, Zip Code						IN, DARDAI	₹A		
P O EN 2100	BLUE CROSS BLUE SHIELD OF NC						27106			
OB/02/1970	P O BOX 2100			WINSTON	IOAL	LLIVI, INC	21 100			
Debatical	WINSTON-SALEM, NC 27102		1	<ol><li>Date of Birth</li></ol>	(MM/E	DD/CCYY)			icyholder/Subscriber IE	(SSN or ID#)
Second   Medical   Medical   (If text), company (Institute Section 14 (Last, Fish, Model Institut, Sulfn)   Section   Sectio				06/02/197	0		M X	F W143	309860	
State of Policy (MMCDICCYY)   7. Gender   8. Policy/older/Subscriber to (SSN or 109)   18. Residencing to Policy/Older/Subscriber to (SSN or 109)   2. Name (a.st. Frat. Middle Initial, Suffix, Jadess, Cly, State, Zp Cade   9. Particification from the Particification fr	OTHER COVERAGE (Mark applicable box and complete items 5-11. If none	, leave blank.)	1	16. Plan/Group I	Numbe	r ′	17. Employer Na	ıme		
Search   Strip (MMDDICCYY)   T. Cender   B. Policyholder/Subscriber ID (SN or IDH)   Saft   Spokes   Quantity   Operated Child   Other	4. Dental? Medical? (If both, complete 5-11 for dental or	nly.)		009424						
Description   Continued   Co	5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		F	PATIENT INF	ORM	ATION				
Spale of Perin (MMCD/CCVY)   10   Perind Foundation   Perind Pe			1	18. Relationship	to Poli	cyholder/Sul	oscriber in #12 A	bove		ed For Future
## STANDING Number	6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscri	ber ID (SSN or	· ID#)	Self	Sp	ouse X	Dependent Chi	ild Othe	er Ose	
Safe			2	20. Name (Last,	First, N	/liddle Initial,	Suffix), Address	s, City, State,	, Zip Code	
11 Other Insurance Company)  Distallar Bernefit   Plan Name, Address. City, State, Zp Code   21. Date of Birth (MMDDCCYY)   22. Gender   08/10/2005   08/10/200	9. Plan/Group Number 10. Patient's Relationship to Person name	d in #5		GATEAU-	CAR	RINGTON	N, LARRIE			
21   Date of Birth (MM/DDCCYY)   22   Gender   23   Patient   Discoverage   4   Assigned by Dentist)   O8/10/2005   Discoverage   24   Date of Birth (MM/DDCCYY)   Discoverage   25   Date of Birth (MM/DDCCYY)   Date o	Self Spouse Depende	ent Othe	r	5372 KING	SSWE	ELL DR				
RECORD OF SERVICES PROVIDED     Services	11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Z	ip Code		WINSTON	I SAL	EM, NC	27106			
RECORD OF SERVICES PROVIDED     Services		L								
RECORD OF SERVICES PROVIDED   28 - Trocolum Date   25 - Month   25 - Month   26 -			2		-	D/CCYY)				gned by Dentist)
1 11/28/2016   1 11/28/2016   2				08/10/200	5			F  80514	48162881 	
24   1726/3014   25   25   26   27   26   25   24   23   22   21   20   18   18   24   25   25   24   23   22   21   20   18   17   25   25   24   23   22   21   20   20   20   20   20   20										
11/28/2016	24. Procedure Date of Oral Tooth 27. Tooth Number(s)						30.	Description		31. Fee
2	Cavity System			Pointer	Qty.	555105	007110 7			100.00
3		L	08670	+		PERIOD	ORTHO IX	INSTALL	_MEN I	192.00
A										
S				+ +						
Comparison   Com										
7				1						
33. Missing Teeth Information (Place an "X" on each missing tooth.)   34. Diagnosis Code List Qualifier   (ICD-9 = B, ICD-10 = AB)   31a. Other Fee(s)   32. 31	6									
33. Missing Teeth Information (Place an "X" on each missing tooth.)   34. Diagnosis Code List Qualifier   (ICD-9 = B, ICD-10 = AB)   31a. Other Fee(s)   32. 31	7									
33. Missing Teeth Information (Place an "X" on each missing tooth.)   34. Diagnosis Code List Qualifier   (ICD-9 = B, ICD-10 = AB )   31a. Other Fee(s)   1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16   34a Diagnosis Code(s) A										
3. Missing Teeth Information   Pilace an "X" on each missing tooth.)   34. Diagnosis Code List Qualifier   (1CD-9 = B; ICD-10 = AB)   31a. Other Fee(s)    1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 34a. Diagnosis Code(s)   A										
1		101.01							104 - 011	
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 (Primary diagnosis in "A") B D 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 11/28/2016 Patient/Guardian Signature Date 44. Replacement 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 45. Treatment Resulting from Coccupational illness/injury Auto accident Other 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  50. License Number 51. SSN or TIN 1144309410  49. NPI 1144309410  50. License Number 51. SSN or TIN 1144309410  40. Carriant disclosure in "Archive Accident State State" Specialty Code 1223X0400X 2016 2016 2016 2016 2016 2016 2016 2016						( ICD-9 =		)		
35. Remarks  AUCILLARY CLAIM/TREATMENT INFORMATION 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  Patent/Cuardian 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  BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  BILLING 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  54. NPI 1790/16421  55. License Number  56. Address, City, State, Zip Code  49. NPI 1790/16421  55. License Number  56. Address, City, State, Zip Code  56a. Provider Specialty Code 1223X0400X  Winston-Salem, NC 27103			•	: «A»\	Α				22 Total Foo	400.00
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/Cuardian 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  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  ANCILLARY CLAIM/TREATMENT INFORMATION  38. Place of Treatment 1 1 1 (e.g. 11=office; 22=O/P Hospital)  (Use "Place of Service Codes for Professional Claims")  49. Is Treatment for Orthordontics?  40. Is Treatment for Orthordontics?  41. Date Appliance Placed (MM/IDD/CCYY)  45. Treatment Resulting from  Coccupational illness/injury Auto accident  Wim/DICCYY)  45. Treatment Resulting from  Coccupational illness/injury Auto accident  Wim/DICCYY)  47. Auto Accident  48. Date Appliance Placed (MM/IDD/CCYY)  49. Ne Placed (Freatment) 1 (Use "Place of Service Codes for Professional Claims")  49. Ne Placed (Remindent)  40. Is Treatment for Orthordontics?  41. Date Appliance Placed (MM/IDD/CCYY)  41. Date Appliance Placed (MM/IDD/CCYY)  42. Months of Treatment (Mm/IDD/CCYY)  45. Treatment Resulting from  Coccupational illness/injury Auto accident  46. Date of Accident (MM/IDD/CCYY)  47. Auto Accident Surface of Treatment (Mm/IDD/CCYY)  48. Date Appliance Placed (MM/IDD/C		17 (Prima	ary diagnosis	sin A)	В		D		32.  00a  Fee	192.00
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 11/28/2016 Subscriber Signature Date	33. Remarks									
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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  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  38. Us Treatment for Orthodontics? 41. Date Appliance Placed (MM/DD/CCYY) 41. Date of Prior Placement (MM/DD/CCYY) 42. Months of Treatment Resulting from Subscriber Signature Date 45. Date 46. Date 67. Treatment Resulting from Occupational illness/fnjury Auto accident Other accident Submitting claim on behalf of the patient or insured/subscriber.)  TREATING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  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 56a. Provider Specially Code 1223X0400X 201 Charlois Blvd Winston-Salem, NC 27103	charges for dental services and materials not paid by my dental benefit plan, u	nless prohibited	d by							
x SIGNATURE ON FILE 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 11/28/2016  38. SIGNATURE ON FILE 11/28/2016  Subscriber Signature Date 41. Date 42. Months of Treatment 43. Replacement of Prosthesis 27 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.)  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 1790716421 55. License Number 51. SSN or TIN 56-2132966  50. License Number 51. SSN or TIN 56-2132966  50. License Number 51. SSN or TIN 56-2132966  50. License Number 51. SSN or TIN 56-2132966	or a portion of such charges. To the extent permitted by law, I consent to your u	use and disclos	ure 40	Is Treatment for	r Ortho	dontics?		41. [	Date Appliance Placed	(MM/DD/CCYY)
Patient/Guardian Signature  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  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  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  49. NPI 1144309410  50. License Number  51. SSN or TIN 56-2132966  51. SSN or TIN 56-2132966  42. Months of Treatment 43. Replacement of Prosthesis 44. Date of Prior Placement (MM/DD/CCYY)  47. Auto Accident (MM/DD/CCYY)  48. Date of Accident (MM/DD/CCYY)  47. Auto Accident State  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  49. NPI 1144309410  50. License Number 51. SSN or TIN 56-2132966  51. SSN or TIN 50. Carlois Blvd Winston-Salem, NC 27103	44/00						(Complete 41-4)			(
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 46. Date 46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State 46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State 48. Name, Address, City, State, Zip Code  Kenneth M. Sadler, DDS and Associates, PA 201 Charlois Boulevard Winston-Salem, NC 27103  50. License Number 51. SSN or TIN 1144309410 50. License Number 56-2132966  27 No Yes (Complete 44)  45. Treatment Resulting from Coccupational illness/injury Auto accident Other accident M. Sat occident (MM/DD/CCYY) 47. Auto Accident State 46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State 46. Date of	X	3/2010	— <del> </del> 42.					- 0,0		t (MM/DD/CCYY)
Signature   Sign	<u> </u>					٦				,
X SIGNATURE ON FILE 11/28/2016 Subscriber Signature Date 46. Date 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 1790716421 55. License Number 4151 56-2132966  50. License Number 51. SSN or TIN 56-2132966  50. License Number 51. SSN or TIN 56-2132966  COccupational illness/injury Auto accident Other accident 46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State  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 56a. Provider Specialty Code 1223X0400X  49. NPI 174309410 4151 56-2132966		ole to me, direct			ulting fr	om	( )	,		
Subscriber Signature  Date  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 1790716421  50. License Number  51. SSN or TIN 1144309410  46. Date of Accident (MM/DD/CCYY)  47. Auto Accident State  47. Auto Accident State  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  49. NPI 1790716421  56. Address, City, State, Zip Code  49. NPI 174309410  4151  50. License Number  51. SSN or TIN 56-2132966  4151	V SIGNATURE ON EUE 11/29	8/2016			-		Auto	accident	Other accider	nt
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 174309410  50. License Number 4151  51. SSN or TIN 56-2132966  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 56a. Provider Specialty Code 1223X0400X  201 Charlois Blvd Winston-Salem, NC 27103	X	· · · · · · · · · · · · · · · · · · ·							47. Auto Accide	nt State
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  4151  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 Specialty Code 1223X0400X  201 Charlois Blvd Winston-Salem, NC 27103	BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or den	_		`		ATMENT LO	CATION II			
48. Name, Address, City, State, Zip Code  Kenneth M. Sadler, DDS and Associates, PA 201 Charlois Boulevard Winston-Salem, NC 27103  49. NPI 1144309410  4151  multiple visits) or have been completed.  X Dr. Martin Slominski Signed (Treating Dentist) Date  54. NPI 1790716421 55. License Number 56. Address, City, State, Zip Code Specialty Code 1223X0400X  201 Charlois Blvd Winston-Salem, NC 27103									es that require	
Kenneth M. Sadler, DDS and Associates, PA 201 Charlois Boulevard Winston-Salem, NC 27103       X Dr. Martin Slominski       11/28/2016         54. NPI 1790716421       55. License Number         56. Address, City, State, Zip Code       56a. Provider Specialty Code 1223X0400X         49. NPI 144309410       50. License Number 4151       56-2132966	48. Name, Address, City, State, Zip Code						P	, , , , , , , , , , , , , , , , , , ,		
201 Charlois Boulevard   Winston-Salem, NC 27103   Signed (Treating Dentist)   Date	1	Kenneth M. Sadler, DDS and Associates, PA							11/28/2016	
Winston-Salem, NC 27103  54. NPI 1790716421 55. License Number 56. Address, City, State, Zip Code 56a. Provider Specialty Code 1223X0400X  49. NPI 144309410 50. License Number 51. SSN or TIN 201 Charlois Blvd Winston-Salem, NC 27103	201 Charlois Boulevard		^-							
49. NPI         50. License Number 1144309410         51. SSN or TIN 56-2132966         201 Charlois Blvd Winston-Salem, NC 27103         56. Provider Specialty Code 1223X0400X	vvinston-Salem, NC 2/103		54. 1	NPI 17907	1642	1	5	5. License Nu	umber	
49. NPI         50. License Number         51. SSN or TIN         201 Charlois Blvd           1144309410         4151         56-2132966         Winston-Salem, NC 27103							5	6a. Provider	e 1223X0400X	
1144505410	49. NPI 50. License Number 51. SSN or 7	ΓΙΝ						. Fooding Code		
52. Phone Number (336) 331-3500   52a. Additional Provider ID   57. Phone Number (336) 331-3500   58. Additional Provider ID   903HC	I I I	66	Win	nston-Salem, N	VC 27	103				
	52. Phone Number (336) 331-3500   52a. Additional Provider ID		57.	Phone Number (33	6) 33	1-3500	5	8. Additional	<sub>D</sub> 903HC	

ADA American Dental Association® Dental	Claim For	m										
HEADER INFORMATION												
1. Type of Transaction (Mark all applicable boxes)												
X Statement of Actual Services Request for Predetermination/Pre	eauthorization											
X EPSDT / Title XIX		$\perp$										
2. Predetermination/Preauthorization Number		- ⊢-				ER INFORMAT						
		-	Policyholder	/Subsc	riber Name (	Last, First, Middle	Initial, Suffix), A	ddress, City, Sta	te, Zip Code			
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	l	⊣ ։	SHIELDS,	ROE	BERT							
Company/Plan Name, Address, City, State, Zip Code     BLUE CROSS BLUE SHIELD OF NC		2	2707 GLE	NHA	VEN LN							
P O BOX 2100		\	WINSTON	I SAL	EM, NC	27106-2318						
WINSTON-SALEM, NC 27102		13	3. Date of Birth	(MM/F	DD/CCYY)	14. Gender	15 Policyhol	der/Subscriber II	D (SSN or ID#)			
· ·			09/23/197	•	,	X M F	W13693		- (,			
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none,	leave blank )	_	6. Plan/Group I		r 1	7. Employer Nam		J-10				
4. Dental? Medical? (If both, complete 5-11 for dental only		_	080960			RA						
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		P/	ATIENT INF	ORM	ATION							
		18	8. Relationship	to Poli	cyholder/Sub	scriber in #12 Abo	ove		ed For Future			
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscribe	er ID (SSN or ID#)		Self	Sp	oouse X	Dependent Child	Other	Use				
MF		20	0. Name (Last,	First, N	Middle Initial,	Suffix), Address, (	City, State, Zip C	Code				
9. Plan/Group Number 10. Patient's Relationship to Person named			SHIELDS,	DEV	'IN I							
Self Spouse Depender		_	2707 GLE									
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip	Code		WINSTON	I SAL	EM, NC 2	27106-2318						
			4 D-t (D:+)	/B 4B 4/5	200200	22 0	00 D-4:4 IF	\\A + # \\A	:			
			<ol> <li>Date of Birth</li> <li>03/11/200</li> </ol>		DD/CCYY)	22. Gender  X M F	8051491	•	igned by Dentist)			
DECORD OF SERVICES PROVIDED			03/11/2001					02000				
RECORD OF SERVICES PROVIDED			T		1							
24. Procedure Date of Oral Tooth 27. Tooth Number(s)	28. Tooth 29. Prod Surface Cod		29a. Diag. Pointer	29b. Qty.		30. De	scription		31. Fee			
1 11/28/2016	D8670	0	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.)	34. Diagnosis				( ICD-9 =	B; ICD-10 = AB )		31a. Other Fee(s)				
	16 34a. Diagnos 17 (Primary diag		` '	Α		c		32. Total Fee	100.50			
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 1 35. Remarks	(Filliary diag	JI IOSIS I	III A )	В		D		oz. Total i ce	199.58			
o. Remaine												
AUTHORIZATIONS		ANC	CILLARY CL	AIM/	TREATME	NT INFORMAT	ION					
36. I have been informed of the treatment plan and associated fees. I agree to be re		38. P	Place of Treatm	ent -	11 (e.g. 11	=office; 22=O/P Hos	pital) 39. Enc	losures (Y or N)				
charges for dental services and materials not paid by my dental benefit plan, unl law, or the treating dentist or dental practice has a contractual agreement with my		l	(Use "Place of	of Service	ce Codes for P	rofessional Claims")						
or a portion of such charges. To the extent permitted by law, I consent to your us of my protected health information to carry out payment activities in connection v		40. Is	s Treatment for	r Ortho	dontics?		41. Date A	Appliance Placed	(MM/DD/CCYY)			
X SIGNATURE ON FILE 11/28/	/2016		No (Ski	p 41-42	Yes	(Complete 41-42)	9/1/201	6				
Patient/Guardian Signature Date		42. N	Months of Trea	tment	I — ' -	cement of Prosthe		f Prior Placemen	nt (MM/DD/CCYY)			
37. I hereby authorize and direct payment of the dental benefits otherwise payable	e to me, directly	1	21		No	Yes (Complete	44)					
to the below named dentist or dental entity.		45. T	Freatment Resu	-				¬				
X SIGNATURE ON FILE 11/28	/2016		<u> </u>		ness/injury	Auto ad	cident	Other accider				
Subscriber Signature Date		_	Date of Accider					47. Auto Accide	ent State			
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental submitting claim on behalf of the patient or insured/subscriber.)	al entity is not	⊢				as indicated by da			os that require			
48. Name, Address, City, State, Zip Code			nultiple visits)				ate are in progre	ss (for procedure	es mai require			
Kenneth M. Sadler, DDS and Associates, PA			Dr. Mortin	Cla	minaki		,	14/20/2046				
201 Charlois Boulevard		<sup>x</sup> -	Dr. Martin Signed (Treat					11/28/2016 Date				
Winston-Salem, NC 27103		54. N	NPI 17907			55.	License Numbe	r				
		_	Address, City, S			56a Spe	. Provider ecialty Code 12	223X0400X				
49. NPI 50. License Number 51. SSN or TI	N		Charlois Blv			Lapt	, 2230					
1144309410 4151 56-213296	6		ston-Salem, I	NC 27	103							
52. Phone Number (336) 331-3500   52a. Additional Provider ID		57. P	Phone Number (33	6) 33	1-3500	58.	Additional Provider ID 90	03HC	· ·			

ADA American Dental Association® Dental Claim	ı Fori	m										
HEADER INFORMATION												
Type of Transaction (Mark all applicable boxes)												
X Statement of Actual Services Request for Predetermination/Preauthorizat	tion											
X EPSDT / Title XIX		L										
2. Predetermination/Preauthorization Number		P	OLICYHOL	DER/S	UBSCRIB	ER INFORMAT	TION (For	Insurance	Company N	lamed in #3)		
		12	2. Policyholder	r/Subsc	riber Name (	Last, First, Middle	e Initial, Su	ffix), Addre	ess, City, Sta	te, Zip Code		
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		᠋.	DARDEN.	CRA	AIG.							
3. Company/Plan Name, Address, City, State, Zip Code			155 RIDG	,								
BLUE CROSS BLUE SHIELD OF NC		- 1	LEWISVIL	_	_	3						
P O BOX 2100		$\perp$										
WINSTON-SALEM, NC 27102			3. Date of Birth	•	DD/CCYY)	14. Gender	-	•		D (SSN or ID#)		
		_	02/23/196			X M I	7713	69441	5			
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank	k.)	_	6. Plan/Group	Numbe		l7. Employer Nar	ne					
4. Dental? Medical? (If both, complete 5-11 for dental only.)		-	080960			RAI						
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		$\vdash$	ATIENT IN						10 Decem	ed For Future		
6 Date of Birth (AMA/DD/CCVV) 7 Conder 0 D 1 1 1 1 10 10 1 1 10 10 10	15.00	-  18	8. Relationship Self		. –	oscriber in #12 Ab Dependent Child		or	Use	ed For Future		
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN	l or ID#)	20				Suffix), Address,						
9. Plan/Group Number 10. Patient's Relationship to Person named in #5		-				Sullix), Address,	City, State	, Zip Code				
	ther		DARDEN, 155 RIDG									
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code		_	LEWISVIL									
				, .	10 27 020							
		21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assign						gned by Dentist)				
			11/12/200	)2		X M D	8051	541628	879			
RECORD OF SERVICES PROVIDED		_										
24. Procedure Date of Oral Tooth 27. Tooth Number(s) 28. Tooth	29. Proce	edure	29a. Diag.	29b.		20. 0	escription			31. Fee		
(MM/DD/CCYY) Cavity System or Letter(s) Surface	Code	e	Pointer	Qty.						31.1 66		
1 11/28/2016	D8670				PERIOD	ORTHO TX	INSTAL	LMENT		247.50		
2												
3												
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9												
10	<u>D.</u> .	0 1	1:10 1:5		(100.0	D 10D 10 AD 1		104	- Oth			
			List Qualifier		( ICD-9 =	B; ICD-10 = AB )	<u> </u>	31	a. Other Fee(s)			
	i. Diagnosi mary diag		. ,	Α		c			. Total Fee	047.50		
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 (Pri 35. Remarks	illary ulay	10515	III A)	В		D			Total Tee	247.50		
o. Nomano												
AUTHORIZATIONS		ANC	CILLARY C	LAIM/	TREATME	NT INFORMA	TION					
36. I have been informed of the treatment plan and associated fees. I agree to be responsible		38. F	Place of Treatn	nent	11 (e.g. 11	=office; 22=O/P Ho	ospital) 3	9. Enclosu	ires (Y or N)			
charges for dental services and materials not paid by my dental benefit plan, unless prohib law, or the treating dentist or dental practice has a contractual agreement with my plan proh			(Use "Place	of Servi	ce Codes for P	rofessional Claims"	)					
or a portion of such charges. To the extent permitted by law, I consent to your use and disc of my protected health information to carry out payment activities in connection with this cla		40. Is	s Treatment fo	r Ortho	dontics?		41.	Date Appli	iance Placed	(MM/DD/CCYY)		
X SIGNATURE ON FILE 11/28/2016			No (Ski	p 41-42	2) X Yes	(Complete 41-42)	) 9/2	28/2016				
Patient/Guardian Signature Date		42. N	Months of Trea	tment	43. Repla	cement of Prosth	esis 44.	Date of Pr	ior Placemen	t (MM/DD/CCYY)		
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, dir	rectly		17		No	Yes (Complete	e 44)					
to the below named dentist or dental entity.		45. T	reatment Res	ulting fr	om							
X SIGNATURE ON FILE 11/28/2016			Occupa	tional ill	ness/injury	Auto a	accident		Other accider	nt		
Subscriber Signature Date		46. D	Date of Accide	nt (MM/	DD/CCYY)			47.	. Auto Accide	nt State		
<b>BILLING DENTIST OR DENTAL ENTITY</b> (Leave blank if dentist or dental entity is r submitting claim on behalf of the patient or insured/subscriber.)	not					ATMENT LOC						
			hereby certify nultiple visits)			as indicated by one of the control o	date are in	progress (	for procedure	es that require		
48. Name, Address, City, State, Zip Code Kenneth M. Sadler, DDS and Associates, PA			, ,									
201 Charlois Boulevard		Χ_	Dr. Martin					11/	28/2016 Date			
Winston-Salem, NC 27103		54 N	NPI 17907			55	i. License N	lumber	Date			
			Address, City,						3X0400X			
49. NPI 50. License Number 51. SSN or TIN			Charlois Blv			[ Sp	ecialty Cod	ae IZZ	JAU40UA			
1144309410 4151 56-2132966			ston-Salem,		103							
52. Phone (336) 331 3500   52a. Additional		57. P	Phone (33	36) 33	1-3500	58	. Additional	I 903I	HC			
Number (336) 331-3300 Provider ID			Number (33	,	. 0000		Provider	<sub>ID</sub> 3001				

ADA American Dent	aı Associ	ation" <b>Dent</b>	ai Ciain	n Forr	n										
HEADER INFORMATION															
Type of Transaction (Mark all application)	cable boxes)														
X Statement of Actual Services	Requ	uest for Predetermination	n/Preauthoriza	tion											
X EPSDT / Title XIX															
2. Predetermination/Preauthorization	Number				P	OLICYHOL	DER/S	UBSCRIB	ER INFORMA	TION (F	or Insuranc	ce Company N	lamed in #3)		
					12	2. Policyholder	/Subsc	riber Name (	Last, First, Midd	lle Initial, S	Suffix), Add	Iress, City, Sta	te, Zip Code		
INSURANCE COMPANY/DENT	TAL BENEFIT	FPLAN INFORMAT	ION		⅃ .	HILL, STE	PHF	ΝV							
3. Company/Plan Name, Address, Cit	y, State, Zip Co	de				2804 FRIE			RCH RD						
BLUE CROSS BLUE SH	IIELD OF N	С				WINSTON			_						
P O BOX 2100	07400				L										
WINSTON-SALEM, NC 2	2/102				13	<ol><li>Date of Birth</li></ol>	n (MM/E	DD/CCYY)	14. Gender		Policyholde	r/Subscriber II	D (SSN or ID#)		
					┸	08/08/195	58		XM	F W1	369268	34			
OTHER COVERAGE (Mark applic	cable box and co	omplete items 5-11. If n	one, leave blan	ık.)	-	6. Plan/Group	Numbe		17. Employer Na	ime					
4. Dental? Medical?	(If both,	complete 5-11 for dent	al only.)		丄	080960		Į F	RAI						
5. Name of Policyholder/Subscriber in	#4 (Last, First,	Middle Initial, Suffix)			P	ATIENT INF	FORM	ATION							
					18	8. Relationship	to Poli	_	oscriber in #12 A	bove		19. Reserve	ed For Future		
6. Date of Birth (MM/DD/CCYY)	7. Gender	8. Policyholder/Sub	scriber ID (SSN	V or ID#)	$\perp$	Self	Sp	ouse X	Dependent Chi	ild O	Other				
	M F				20	0. Name (Last,	First, N	Middle Initial,	Suffix), Address	s, City, Sta	te, Zip Coo	de			
9. Plan/Group Number		elationship to Person na				HILL, MOF	-								
	Self			ther	_	2804 FRIE									
11. Other Insurance Company/Dental	Benefit Plan Na	ame, Address, City, Stat	e, Zip Code			WINSTON	I SAL	EM, NC	27107						
					21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Ass										
					21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Ass						gned by Dentist)				
					09/08/2000										
RECORD OF SERVICES PROVIDED								ı							
(MM/DD/CCVV) of Oral	Tooth 4	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Proce Code		29a. Diag. Pointer	29b. Qty.		30.	Description			31. Fee		
1 11/28/2016	System			D8670				DEDIOD	ORTHO TX	/ INIQTA	LIMENI	т	206.25		
2				100070				FLIXIOD	OKITIO IX	INSTA	LLIVILIN	!	200.23		
3															
4															
5															
6															
7															
8															
9															
10															
33. Missing Teeth Information (Place a	en "Y" on each r	nissing tooth \	24	Diagnosis	Codo	List Qualifier		(ICD 9 =	B; ICD-10 = AB	`	13	31a. Other			
1 2 3 4 5 6 7	8 9 10			a. Diagnosis			<u></u>	(100-3 =	C	,	——)`	Fee(s)			
32 31 30 29 28 27 26		22 21 20 19		imary diagr		:- "A"\	^		C		—	32. Total Fee	206.25		
35. Remarks	20 21 20	22 21 20 10		many analys		7.,	В		<u> </u>				200.23		
AUTHORIZATIONS				Т	ANC	CILLARY CI	LAIM/	TREATME	NT INFORMA	ATION					
36. I have been informed of the treatm					38. F	Place of Treatm	nent -	11 (e.g. 11	=office; 22=O/P H	lospital)	39. Enclos	sures (Y or N)			
charges for dental services and ma law, or the treating dentist or dental						(Use "Place	of Service	ce Codes for P	rofessional Claims	s")					
or a portion of such charges. To the of my protected health information					40. Is	s Treatment fo	r Ortho	dontics?		41	1. Date App	oliance Placed	(MM/DD/CCYY)		
X SIGNATURE ON			/28/2016			No (Skij	p 41-42	Yes	(Complete 41-42	2) g	9/30/201	6			
Patient/Guardian Signature		Dai			42. N	Months of Trea	tment	43. Repla	cement of Prosti	hesis 44	4. Date of F	Prior Placemen	t (MM/DD/CCYY)		
37. I hereby authorize and direct payr	ment of the dent	al henefits otherwise na	vahle to me, di	rectly		21		No	Yes (Comple	te 44)					
to the below named dentist or den		ai berielits otherwise pe	lyable to me, ui	lectly	45. T	reatment Res	ulting fr	om							
χ SIGNATURE ON	FILE	11	/28/2016	- 1		Occupat	tional ill	ness/injury	Auto	accident		Other accider	nt		
Subscriber Signature		Dai		— t	46. D	Date of Accider	nt (MM/	DD/CCYY)			4	7. Auto Accide	nt State		
BILLING DENTIST OR DENTA	L ENTITY (L	eave blank if dentist or	dental entity is	not	TRE	EATING DE	NTIST	AND TRE	ATMENT LO	CATION	INFOR	MATION			
submitting claim on behalf of the patie	ent or insured/su	ibscriber.)	,	ŀ	53. I	hereby certify	that the	e procedures	as indicated by	date are i	in progress	(for procedure	es that require		
48. Name, Address, City, State, Zip C	ode				n	nultiple visits)	or have	been compl	eted.						
Kenneth M. Sadler, DDS and	Associates,	PA			X	Dr. Martin	Slo	minski			11	/28/2016			
201 Charlois Boulevard					^_	Signed (Trea						Date			
Winston-Salem, NC 27103				Ī	54. N	NPI 17907	1642	1	I .	5. License					
					56. A	Address, City, S	State, Z	ip Code	5	6a. Provide Specialty C	ler ode 122	23X0400X			
	License Numbe	I				Charlois Blv		400		, -					
1144309410 41	51	56-213	2966			ston-Salem, I	NC 27	103							
52. Phone Number (336) 331-3500		52a Additional Provider ID			57. F	Phone Number (33	36) 33	1-3500	5	<ol><li>Addition Provide</li></ol>	nal er ID 903	BHC			

<b>ADA</b> American Dental Association® <b>Dental</b>	Claim F	orm										
HEADER INFORMATION												
1. Type of Transaction (Mark all applicable boxes)												
X Statement of Actual Services Request for Predetermination/Pr	reauthorization											
X EPSDT / Title XIX												
2. Predetermination/Preauthorization Number		-				R INFORMATI						
		1	12. Policyholder	/Subsc	riber Name (I	ast, First, Middle	nitial, Suffix), Ad	ddress, City, Sta	te, Zip Code			
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	N		DOWNS, I	DAVI	ID							
Company/Plan Name, Address, City, State, Zip Code     BLUE CROSS BLUE SHIELD OF NC			3931 TAL									
P O BOX 2100			WINSTON	I SAL	LEM, NC	27106						
WINSTON-SALEM, NC 27102		1	13. Date of Birth	(MM/E	DD/CCYY)	14. Gender	15. Policyholo	der/Subscriber II	O (SSN or ID#)			
			04/13/198	30	,	X M F	W167279		,			
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none,	, leave blank.)	1	16. Plan/Group I		r 1	7. Employer Name						
4. Dental? Medical? (If both, complete 5-11 for dental or	nly.)		075149		E	BCBS						
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		F	PATIENT INF	ORM	ATION							
		1	18. Relationship	to Poli	cyholder/Sub	scriber in #12 Abo	ve		ed For Future			
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscril	ber ID (SSN or	ID#)	Self	Sp	oouse X	Dependent Child	Other	Use				
MF		2	20. Name (Last,	First, N	Middle Initial,	Suffix), Address, C	city, State, Zip C	ode				
9. Plan/Group Number 10. Patient's Relationship to Person named			DOWNS, I									
Self Spouse Depende			3931 TAL			7400						
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zi	ip Code		WINSTON	SAL	LEM, NC 2	2/106						
			21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assi					aned by Dentist)				
		١	02/09/200		55,0011)	M X F	80515716		grica by Bornioty			
RECORD OF SERVICES PROVIDED						100000						
24 Procedure Date 25. Area 26. 27 Tooth Number(s)	28. Tooth 29	9. Procedure	e 29a. Diag.	29b.								
(MM/DD/CCYY) of Oral Cavity System Tooth Cavity System	Surface	Code	Pointer	Qty.		30. De:	scription		31. Fee			
1 11/28/2016	D	8670	PERIOD ORTHO TX INSTALLMENT						239.50			
2												
3												
4												
5												
6												
9												
10												
33. Missing Teeth Information (Place an "X" on each missing tooth.)	34 Dia	anosis Code	e List Qualifier		(ICD-9 =	B; ICD-10 = AB )		31a. Other				
· · · · · · · · · · · · · · · · · · ·		iagnosis Cod	1.7.	A	(112	С		Fee(s)				
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18	17 (Primar	ry diagnosis		В		D		32. Total Fee	239.50			
35. Remarks												
AUTHORIZATIONS		_				NT INFORMAT						
36. I have been informed of the treatment plan and associated fees. I agree to be r charges for dental services and materials not paid by my dental benefit plan, ur		all 38. I by		_		=office; 22=O/P Hos	oital) 39. Encl	osures (Y or N)				
law, or the treating dentist or dental practice has a contractual agreement with m or a portion of such charges. To the extent permitted by law, I consent to your u		ura —				rofessional Claims")	14.5.4		###PD/00\00			
of my protected health information to carry out payment activities in connection	with this claim.		Is Treatment for No (Skip			Complete 41-42)			(MM/DD/CCYY)			
X SIGNATURE ON FILE 11/28 Patient/Guardian Signature Date	3/2016	_	Months of Treat			cement of Prosthes	10/5/20		t (MM/DD/CCYY)			
			18	unone	No	Yes (Complete		T Hor Flacemen	(MINIBB/COTT)			
37. I hereby authorize and direct payment of the dental benefits otherwise payable to the below named dentist or dental entity.	le to me, directi		Treatment Resu	ulting fr	om							
X SIGNATURE ON FILE 11/28	3/2016		Occupat	tional ill	ness/injury	Auto ac	cident	Other accider	nt			
Subscriber Signature Date	46.	Date of Accider	nt (MM/	DD/CCYY)			47. Auto Accide	nt State				
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dent	TR	EATING DEN	NTIST	AND TRE	ATMENT LOCA	TION INFOR	RMATION					
submitting claim on behalf of the patient or insured/subscriber.)						as indicated by da	te are in progres	ss (for procedure	es that require			
48. Name, Address, City, State, Zip Code			multiple visits)	or have	been comple	eted.						
Kenneth M. Sadler, DDS and Associates, PA		Ιx	Dr. Martin				1	1/28/2016				
201 Charlois Boulevard Winston-Salem, NC 27103		Signed (Treating Dentist) Date										
, i			NPI 17907				License Number Provider					
10 ND	-15.1		Address, City, S		ip Code	Spe	cialty Code 12	23X0400X				
49. NPI 50. License Number 51. SSN or T 1144309410 4151 56-213296			1 Charlois Blvd nston-Salem, I		103							
52. Phone (236) 234 3500   52a. Additional		57.	Phone (22			58.7	Additional 00	13HC				
Number (336) 331-3500 S2a. Additional Provider ID			Number (33	iu) 33	1-3500		Additional Provider ID 90	いロし				

ADA American Dental Association® Dental C	laim For	m										
HEADER INFORMATION												
Type of Transaction (Mark all applicable boxes)												
X Statement of Actual Services Request for Predetermination/Pread	uthorization											
X EPSDT / Title XIX												
2. Predetermination/Preauthorization Number		Р	OLICYHOLI	DER/S	UBSCRIBI	ER INFORMA	TION (For Ins	urance Company N	amed in #3)			
		12	<ol><li>Policyholder.</li></ol>	/Subsc	riber Name (I	_ast, First, Middl	e Initial, Suffix)	, Address, City, Stat	te, Zip Code			
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION			ANTHON	/ KE	GRIS							
3. Company/Plan Name, Address, City, State, Zip Code			830 BITTII									
BLUE CROSS BLUE SHIELD OF NC		- 1	RURAL H			5						
P O BOX 2100												
WINSTON-SALEM, NC 27102			<ol><li>Date of Birth</li></ol>	`	DD/CCYY)	14. Gender	1	holder/Subscriber II	O (SSN or ID#)			
		_	08/29/198			M X		0258				
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, lea	· · · · · · · · · · · · · · · · · · ·	_	6. Plan/Group I	Numbe		7. Employer Na	me					
4. Dental? Medical? (If both, complete 5-11 for dental only.)	1		008557			BCBS						
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		-	ATIENT INF					140 8	455.t			
C Data of Digit (AMA/DD/COVA)		18			_	scriber in #12 A		Use	ed For Future			
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber	ID (SSN or ID#)		Self	<u> </u>		Dependent Chil		- 0 - 1 -				
9. Plan/Group Number 10. Patient's Relationship to Person named in	#5	_				Suffix), Address	, City, State, Zip	p Code				
Self Spouse Dependent	Other		ANTHON)									
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip O		_	830 BITTII RURAL H			5						
The other initiation company/bornal benefit har Hairie, / hadress, only, orate, ap c	,ouc		TOTO LI	, , LL,	110 27040	,						
		21	1. Date of Birth	(MM/E	DD/CCYY)	22. Gender	23. Patient	t ID/Account # (Assi	gned by Dentist)			
			11/30/200	)3		M X	F 805169	162876				
RECORD OF SERVICES PROVIDED												
24. Procedure Date 25. Area 26. 27. Tooth Number(s) 28.	Tooth 29. Pro	cedure	29a. Diag.	29b.		20.1	\		24 5			
	rface Co	de	Pointer	Qty.		30. 1	Description		31. Fee			
1 11/28/2016	D867	0	PERIOD ORTHO TX INSTALLMENT						266.11			
2												
3												
4												
5												
6												
7												
8												
9												
	10101		11.10 115					04 - 04 -				
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			List Qualifier		( ICD-9 =	B; ICD-10 = AB	)	31a. Other Fee(s)				
	34a. Diagnos (Primary dia		. ,	Α		c		- 32. Total Fee	000.44			
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 35. Remarks	(Filliary dia	griosis	III A)	В		D		_   02. 10tal 1 cc	266.11			
o. Nomano												
AUTHORIZATIONS		ANG	CILLARY CL	AIM/	TREATMEI	NT INFORMA	TION					
36. I have been informed of the treatment plan and associated fees. I agree to be resp		38. F	Place of Treatm	ent -	11 (e.g. 11	=office; 22=O/P H	ospital) 39. E	inclosures (Y or N)				
charges for dental services and materials not paid by my dental benefit plan, unles law, or the treating dentist or dental practice has a contractual agreement with my p	lan prohibiting all	l	(Use "Place of	of Service	ce Codes for P	rofessional Claims	")					
or a portion of such charges. To the extent permitted by law, I consent to your use of my protected health information to carry out payment activities in connection wit		40. Is	s Treatment fo	r Ortho	dontics?		41. Dat	e Appliance Placed	(MM/DD/CCYY)			
X SIGNATURE ON FILE 11/28/2		l	No (Ski	p 41-42	2) X Yes (	Complete 41-42	) 10/20	0/2016				
Patient/Guardian Signature Date		42. N	Months of Trea	tment	43. Replac	cement of Prosth	esis 44. Date	e of Prior Placemen	t (MM/DD/CCYY)			
37. I hereby authorize and direct payment of the dental benefits otherwise payable to	o me, directly	<u> </u>	16		No	Yes (Complet	e 44)					
to the below named dentist or dental entity.		45. T	Treatment Resu	ulting fr	om							
X SIGNATURE ON FILE 11/28/2	016		Occupat	tional ill	ness/injury	Auto	accident	Other accider	nt			
Subscriber Signature Date		46. E	Date of Accider	nt (MM/	DD/CCYY)			47. Auto Accide	nt State			
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental e submitting claim on behalf of the patient or insured/subscriber.)	entity is not	⊢				ATMENT LO						
			hereby certify multiple visits) o				date are in pro	gress (for procedure	es that require			
48. Name, Address, City, State, Zip Code		l										
Kenneth M. Sadler, DDS and Associates, PA 201 Charlois Boulevard		X_	Dr. Martin					11/28/2016				
Winston-Salem, NC 27103		54 N	Signed (Treat			5.0	5. License Num	Date				
		_	NPI 17907 Address, City, S									
49. NPI 50. License Number 51. SSN or TIN		-	Charlois Blvo		p 000e	S	pecialty Code	1223X0400X				
1144309410 4151 56-2132966			ston-Salem, I		103							
52. Phone (236) 221 2500   52a. Additional		57. F	Phone (33	6) 33	1-3500	58	B. Additional Provider ID	903HC				
Number (336) 331-3300 Provider ID		1 1	Number (33	.5) 55	5500		Provider ID	5001 IC				

Αl	<b>DA</b> American L	ent	al As	SOCI	ation*	⊔ent	al Clai	m For	m										
HE	ADER INFORMATION	1																	
1.	Гуре of Transaction (Mark a —	all applic	able bo	xes)															
1 5	X Statement of Actual Se	rvices		Requ	est for Prede	eterminatio	n/Preauthori	zation											
<u> </u>	X EPSDT / Title XIX								┵										
2.1	Predetermination/Preauthor	rization	Number										ER INFORMAT						
$\vdash$									— 12	2. Policyholde	r/Subsc	riber Name (	Last, First, Middle	Initial, Su	uffix), Addre	ess, City, Sta	te, Zip Code		
$\vdash$	SURANCE COMPANY					FORMAT	ION		┦,	CALIFF, N	ИARК	ΚK							
3. (	Company/Plan Name, Addr BLUE CROSS BLU	-		•					-   -	7612 SEC	GEV	VICK RID	GE RD						
ı	P O BOX 2100	JE 3H	IELD	OF IN						LEWISVIL	LE, î	NC 27023	3						
ı	WINSTON-SALEM	. NC 2	27102						13	3. Date of Birtl	n (MM/F	OD/CCYY)	14. Gender	15 Pc	olicyholder/	/Subscriber II	D (SSN or ID#)		
ı	-	, -								08/06/197	•	35,0011)	X M F	.	3694118		5 (5511 511)		
o	HER COVERAGE (Mai	rk applic	able bo	x and co	mplete items	5-11 If no	one leave bl	ank )	_	6. Plan/Group		er 1	7. Employer Nam		505-116				
-	Dental? Medica	<del></del>			complete 5-1			ariic.)	_	080960			RAI						
5. 1	Name of Policyholder/Subs	criber in	#4 (La:	st, First,	Middle Initial	, Suffix)			P.	ATIENT IN	FORM	ATION							
ı	-								18	3. Relationship	to Poli	icyholder/Sub	scriber in #12 Ab	ove		19. Reserv	ed For Future		
6. 1	Date of Birth (MM/DD/CCY	Y)	7. Gend	der	8. Policyh	nolder/Sub	scriber ID (S	SN or ID#)		Self	Sp	oouse X	Dependent Child	Otl	her	Use			
ı			M	F					20	). Name (Last	, First, I	Middle Initial,	Suffix), Address,	City, State	e, Zip Code	9			
9. 1	Plan/Group Number		10. Pati	ent's Re	lationship to	Person na	med in #5			CALIFF, k	KENS	LEA L							
			Se	elf	Spouse	Depe	endent	Other		7612 SEC	GEW	ICK RID	GE RD						
11.	Other Insurance Company	/Dental	Benefit	Plan Na	me, Address,	City, State	e, Zip Code		LEWISVILLE, NC 27023										
l									L				,						
ı									- 1	1. Date of Birtl		DD/CCYY)	22. Gender			•	igned by Dentist)		
ㄴ										06/30/200	)4		M X F	805	111162	875			
RE	RECORD OF SERVICES PROVIDED																		
П	<ol> <li>Procedure Date (MM/DD/CCYY)</li> </ol>	of Oral	Tooth	2	7. Tooth Numb or Letter(s)	er(s)	28. Tooth Surface	29. Pro Co		29a. Diag. Pointer	29b. Qty.		30. De	escription			31. Fee		
1	11/28/2016	Cavity	System					D867	n			PERIOD	ORTHO TX I	NSTAI	IMENT		199.58		
2	11/20/2010											LITTOD	ORTHO TAT	1101712	LIVILIAI		100.00		
3																			
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7																			
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9																			
10																			
33.	Missing Teeth Information	•								List Qualifier		( ICD-9 =	B; ICD-10 = AB )		31	Ia. Other Fee(s)			
⊢		5 7		9 10	11 12 1			34a. Diagnos		. ,	Α		C			2. Total Fee			
⊢	32 31 30 29 28 2 Remarks	7 26	25 2	4 23	22 21 2	0 19 1	8 17 (	Primary dia	gnosis	ın " <b>A</b> ")	В		D		32	z. Total Fee	199.58		
35.	Remarks																		
	JTHORIZATIONS								LANG	CILLARY C	ΔIM/	TREATME	NT INFORMAT	ION					
-	I have been informed of the	e treatm	ent plan	and ass	ociated fees.	I agree to	be responsib	le for all	-				=office; 22=O/P Hos		39. Enclosu	ıres (Y or N)			
ı	charges for dental services law, or the treating dentist of								l		_		rofessional Claims")						
ı	or a portion of such charge of my protected health info	s. To the	extent	permitte	d by law, I cor	nsent to yo	ur use and d	isclosure	40. Is	s Treatment fo	r Ortho	dontics?		41.	. Date Appl	iance Placed	(MM/DD/CCYY)		
lχ	SIGNATURE		,	out pays	nent delivities		/28/2016		l	No (Ski	ip 41-42	2) X Yes	(Complete 41-42)	4/	/20/2016	i			
	Patient/Guardian Signature					Dat			42. N	Months of Trea	tment	43. Repla	cement of Prosthe	sis 44.	. Date of Pr	ior Placemen	t (MM/DD/CCYY)		
37.	I hereby authorize and dire	ect payn	nent of t	he denta	al benefits oth	nerwise pa	yable to me,	directly		16		No	Yes (Complete	44)					
ı	to the below named dentis	t or den	tal entity	y.				-	45. T	reatment Res	ulting fr	rom	_						
x	SIGNATURE	ON	FILE			11	/28/2016	<u> </u>		Occupa	tional ill	ness/injury	Auto a	ccident		Other accider	nt		
L	Subscriber Signature					Dat	е		46. E	ate of Accide	nt (MM/	DD/CCYY)			47	. Auto Accide	ent State		
	LLING DENTIST OR I mitting claim on behalf of t					dentist or	dental entity	is not	⊢				ATMENT LOC						
╙				Jul Cur Ju	bootiber.)					hereby certify nultiple visits)			as indicated by deted.	ate are in	progress (	(for procedure	es that require		
	Name, Address, City, State			niatos	DΛ				l	. ,		·							
	enneth M. Sadler, DD 01 Charlois Boulevard		A5500	Jales,	. ^				X_	Dr Debora					11/	28/2016 Date			
	inston-Salem, NC 27								54 N	NPI 14574			55	License I	Number	Date			
									-	ddress, City,						3X0400X			
49	NPI	50	License	Numbe	r	51. SSN	or TIN		-	Charlois Blv			Spe	ecialty Co	ae IZZ	JAU40UX			
	44309410	41				56-213				ston-Salem,		103							
52.	Phone Number (336) 331-35	500			52a. Additio	nal or ID			57. F	Phone Number (33	36) 33	1-3500	58.	Additiona Provider	al				

ADA American Dental Association® Dental Claim	n Forr	n								
HEADER INFORMATION										
1. Type of Transaction (Mark all applicable boxes)										
X Statement of Actual Services Request for Predetermination/Preauthoriza	ation	1								
X EPSDT / Title XIX		┶								
2. Predetermination/Preauthorization Number		-						N (For Insurance		
		- 12	2. Policyholder	r/Subsc	riber Name (	Last, First, Mide	dle Init	ial, Suffix), Addr	ess, City, Sta	te, Zip Code
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		-  1	POWELL,	MAN	NDY K					
Company/Plan Name, Address, City, State, Zip Code     BLUE CROSS BLUE SHIELD OF NC		'	101 BRIT	TANY	/ CT					
P O BOX 2100			KING, NC	2702	21-8806					
WINSTON-SALEM, NC 27102		13	B. Date of Birth	n (MM/E	DD/CCYY)	14. Gender		15. Policyholder	/Subscriber II	D (SSN or ID#)
			09/03/197		,	│	- 1	W1369460		,
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blan	nk.)	-	6. Plan/Group		r 1	7. Employer Na				
4. Dental? Medical? (If both, complete 5-11 for dental only.)		1	080960		F	RAI				
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		P/	ATIENT IN	FORM	ATION					
		18	B. Relationship	to Poli	icyholder/Sub	scriber in #12	Above			ed For Future
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SS	N or ID#)	┖	Self	Sp	oouse X	Dependent Ch	ild [	Other	Use	
MF		20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
9. Plan/Group Number 10. Patient's Relationship to Person named in #5	241-		POWELL,							
	Other	_	101 BRIT							
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code			KING, NC	2/02	21-8806					
		21	. Date of Birth	MM/F	DD/CCYY)	22. Gender	1	23 Patient ID/Ad	ccount # (Assi	igned by Dentist)
			06/24/200		55,0011)	M X		805117162		griod by Borniot,
RECORD OF SERVICES PROVIDED		_					,			
24 Procedure Date 25. Area 26. 27 Tooth Number(s) 28 Tooth	29. Proce	dure	29a. Diag.	29b.		20	Danasi	-4:		24 5
(MM/DD/CCYY) of Oral Cavity System or Letter(s) Surface	Code	•	Pointer	Qty.		30.	Descri	puon		31. Fee
1 11/28/2016	D8670				PERIOD	ORTHO T	K INS	TALLMENT	•	206.25
2										
3										
5										
6										
8										
9										
10										
33. Missing Teeth Information (Place an "X" on each missing tooth.)	. Diagnosis	Code	List Qualifier		( ICD-9 =	B; ICD-10 = AE	3)	3	1a. Other	
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 34	a. Diagnosis	Code	e(s)	Α		c			Fee(s)	
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 (P	rimary diagr	nosis i	in " <b>A</b> ")	В		D		33	2. Total Fee	206.25
35. Remarks										
<b>AUTHORIZATIONS</b> 36. I have been informed of the treatment plan and associated fees. I agree to be responsible	for all					=office; 22=O/P I			ures (Y or N)	
charges for dental services and materials not paid by my dental benefit plan, unless prohillaw, or the treating dentist or dental practice has a contractual agreement with my plan pro	bited by	J0. I		_		rofessional Claim		1) 00. E110103		
or a portion of such charges. To the extent permitted by law, I consent to your use and dis	closure	40. Is	Treatment fo	r Ortho	dontics?			41, Date App	liance Placed	(MM/DD/CCYY)
of my protected health information to carry out payment activities in connection with this c  X SIGNATURE ON FILE 11/28/2016	laim.		No (Ski			(Complete 41-4	2)	5/4/2016		(
Patient/Guardian Signature Date		42. N	Months of Trea	tment		cement of Prost			rior Placemen	it (MM/DD/CCYY)
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, d	lirectly		17		No	Yes (Comple	ete 44)			
to the below named dentist or dental entity.		45. T	reatment Res	ulting fr	om					
X SIGNATURE ON FILE 11/28/2016			Occupa	tional ill	ness/injury	Auto	accid	ent	Other accider	nt
Subscriber Signature Date		46. D	ate of Accide	nt (MM/	DD/CCYY)			47	7. Auto Accide	ent State
<b>BILLING DENTIST OR DENTAL ENTITY</b> (Leave blank if dentist or dental entity is submitting claim on behalf of the patient or insured/subscriber.)	- 1							ION INFORM		
, , , , , , , , , , , , , , , , , , ,			hereby certify nultiple visits)				/ date	are in progress	(for procedure	es that require
48. Name, Address, City, State, Zip Code Kenneth M. Sadler, DDS and Associates, PA			, ,		·				100100:5	
201 Charlois Boulevard		Χ_	Dr Debora Signed (Trea					11/	/28/2016 Date	
Winston-Salem, NC 27103	ŀ	54. N	IPI 14574			1	55. Lic	ense Number	Daio	
	ŀ		ddress, City,					rovider Ity Code 122	3X0400¥	
49. NPI 50. License Number 51. SSN or TIN			Charlois Blv			Ŀ	opecia	ny Code IZZ	5710 <del>1</del> 007	
1144309410 4151 56-2132966		Wins	ston-Salem,	NC 27	103					
52. Phone Number (336) 331-3500 52a. Additional Provider ID		57. P	hone lumber (33	36) 33	1-3500		8. Add	ditional ovider ID		

ADA American Dental Association® Dental Clair	m Fori	m										
HEADER INFORMATION												
1. Type of Transaction (Mark all applicable boxes)												
X Statement of Actual Services Request for Predetermination/Preauthorize	ation											
X EPSDT / Title XIX		╄										
2. Predetermination/Preauthorization Number		_				ER INFORMA		•				
		<b>-</b> 1 <sup>12</sup>	2. Policyholdei	r/Subsc	riber Name (	Last, First, Midd	le Initial	l, Suffix), Addr	ress, City, Sta	te, Zip Code		
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		ا  -	POTTS, F	RYAN	J							
Company/Plan Name, Address, City, State, Zip Code     BLUE CROSS BLUE SHIELD OF NC		-	145 NOR\	woo	D FORE	ST LANE						
P O BOX 2100		-	TOBACC	OVILI	LE, NC 2	7050						
WINSTON-SALEM, NC 27102		13	B. Date of Birth	h (MM/E	DD/CCYY)	14. Gender	15	5. Policyholder	r/Subscriber II	D (SSN or ID#)		
		- 1	11/06/197	•	,	l — —	_	V1369428		- (,		
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave bla	ınk.)	_	6. Plan/Group		er /	17. Employer Na		1000120				
4. Dental? Medical? (If both, complete 5-11 for dental only.)	,	1	080960		F	RAI						
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		P	ATIENT IN	FORM	ATION							
		18	3. Relationship	to Poli	icyholder/Sul	oscriber in #12 A	bove			ed For Future		
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SS	SN or ID#)		Self	Sp	oouse X	Dependent Chi	ld 🗌	Other	Use			
MF		20	). Name (Last	, First, I	Middle Initial,	Suffix), Address	s, City, S	State, Zip Cod	le			
9. Plan/Group Number 10. Patient's Relationship to Person named in #5			POTTS, E	ELLIE	J							
Self Spouse Dependent C	Other	_	5010 MAY									
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code			WINSTON	N-SAL	EM, NC	27106						
				(2.22.27	200000	Tag. 6	100					
		- 1	<ol> <li>Date of Birth</li> <li>04/28/200</li> </ol>		DD/CCYY)	22. Gender	- 1	3. Patient ID/A 05070162	,	igned by Dentist)		
			04/20/200	J <del>4</del>		w _ <b>_</b>	'   00	03070102	.073			
RECORD OF SERVICES PROVIDED	00.5		00 - B'	001	Ι							
24. Procedure Date (MM/DD/CCYY) of Oral County System 27. Tooth Number(s) 28. Tooth Cavity System 28. Tooth Surface	29. Proce		29a. Diag. Pointer	29b. Qty.		30. I	Descripti	ion		31. Fee		
1 11/28/2016	D8670				PERIOD	ORTHO TX	INST	ALLMENT	-	206.25		
2												
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7												
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9												
23. Missing Teath Information (Disease WV) as each principal teath.)	4 Diamaraia	0 - 1 -	List Ossellifes		(100.0	D: 10D 40 - AD	`	10	1a. Other			
	4a. Diagnosis		List Qualifier		(100-9=	B; ICD-10 = AB	)		Fee(s)			
	rimary diagi		` '	Α		C		3:	2. Total Fee	206.25		
35. Remarks	Times y arange		,	В		U				200.23		
AUTHORIZATIONS		ANC	CILLARY C	LAIM/	TREATME	NT INFORMA	TION					
36. I have been informed of the treatment plan and associated fees. I agree to be responsible charges for dental services and materials not paid by my dental benefit plan, unless prohi		38. F	Place of Treatn	nent [	11 (e.g. 11	l=office; 22=O/P H	lospital)	39. Enclos	ures (Y or N)			
law, or the treating dentist or dental practice has a contractual agreement with my plan pro	hibiting all		(Use "Place	of Servi	ce Codes for P	rofessional Claims	5")					
or a portion of such charges. To the extent permitted by law, I consent to your use and dis of my protected health information to carry out payment activities in connection with this or		40. Is	s Treatment fo					41. Date App	liance Placed	(MM/DD/CCYY)		
X SIGNATURE ON FILE 11/28/2016			No (Ski			(Complete 41-42		1/5/2016				
Patient/Guardian Signature Date		42. N	Months of Trea	atment	I — ' -	cement of Prostr	- 1	44. Date of P	rior Placemen	it (MM/DD/CCYY)		
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, of to the below named dentist or dental entity.	directly	4E T	12 reatment Res		No	Yes (Complet	te 44)					
·		45. 1		-	ness/injury	☐ Auto	accider	nt 🗆	Other accider	nt		
X SIGNATURE ON FILE 11/28/2016 Subscriber Signature Date	<b> </b>	46 F	Date of Accide				4001401		7. Auto Accide			
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is	: not					ATMENT LO	CATIC			The Otale		
submitting claim on behalf of the patient or insured/subscriber.)	5 1101					as indicated by				es that require		
48. Name, Address, City, State, Zip Code			nultiple visits)					p g	( p			
Kenneth M. Sadler, DDS and Associates, PA		v	Dr Debora	ah F∃	Novak			11.	/28/2016			
201 Charlois Boulevard		^_	Signed (Trea					11/	Date			
Winston-Salem, NC 27103		54. N	<sup>IPI</sup> 14574	14142	200			nse Number				
		56. A	ddress, City,	State, Z	ip Code	5/ S	6a. Prov pecialty	vider Code 122	3X0400X			
49. NPI 50. License Number 51. SSN or TIN			Charlois Blv		103							
1144309410 4151 56-2132966			ston-Salem,			1.5	0 1 4 4 1 1 1 1	ional				
52. Phone Number (336) 331-3500 52a. Additional Provider ID		۶۲. F ۸	Phone Jumber (33	36) 33	1-3500		8. Additi Provi	ional ider ID				

ADA American Dental Association® Dental Cla	ıım Fori	m									
HEADER INFORMATION											
1. Type of Transaction (Mark all applicable boxes)											
X Statement of Actual Services Request for Predetermination/Preautho	orization										
X EPSDT / Title XIX		╄									
2. Predetermination/Preauthorization Number		-				ER INFORMA		•			
		<b>1</b> 2	2. Policyholder	r/Subsc	riber Name (	Last, First, Midd	lle Initia	al, Suffix), Add	lress, City, Sta	ite, Zip Code	
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		վ (	CLYBURN	۱, JAI	MES						
Company/Plan Name, Address, City, State, Zip Code     BLUE CROSS BLUE SHIELD OF NC		7	7457 PRII	NCES	SS ANN (	CT					
P O BOX 2100			RURAL H	ALL,	NC 2704	5-9821					
WINSTON-SALEM, NC 27102		13	3. Date of Birth	n (MM/E	DD/CCYY)	14. Gender	1	5. Policyholde	r/Subscriber II	D (SSN or ID#)	
			01/14/197	76	,	l — —	-	v1369382		,	
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave	blank.)	_	6. Plan/Group		r 1	7. Employer Na					
4. Dental? Medical? (If both, complete 5-11 for dental only.)			080960		F	RAI					
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		P/	ATIENT IN	FORM	ATION						
		18	8. Relationship	to Poli	cyholder/Sub	scriber in #12 A	Above	_	19. Reserv Use	ed For Future	
6. Date of Birth (MM/DD/CCYY)  7. Gender  8. Policyholder/Subscriber ID (	(SSN or ID#)	L	Self	Sp	oouse X	Dependent Chi	ild	Other	Use		
MF		20	0. Name (Last,	, First, N	Middle Initial,	Suffix), Address	s, City,	State, Zip Coo	de		
9. Plan/Group Number 10. Patient's Relationship to Person named in #5	$\neg$		CLYBURN	•		_					
Self Spouse Dependent	Other	_	7457 PRI								
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	е	RURAL HALL, NC 27045-9821									
		21	1. Date of Birth	n (MM/E	DD/CCYY)	22. Gender	2:	3. Patient ID/A	ccount # (Assi	igned by Dentist)	
			05/07/200	-	,			05099162		, , ,	
RECORD OF SERVICES PROVIDED											
24. Procedure Date 25. Area 26. 27. Tooth Number(s) 28. Too	oth 29. Proce	edure	29a. Diag.	29b.		30	Docorini	tion		31. Fee	
(MM/DD/CCYY) of Oral Total System or Letter(s) Surface	e Code	e	Pointer	Qty.		30.	Descript	uon		31. Fee	
1 11/28/2016	D8670				PERIOD	ORTHO TX	(INS	TALLMEN	Γ	159.67	
2											
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9											
10											
33. Missing Teeth Information (Place an "X" on each missing tooth.)	34. Diagnosis	Code	List Qualifier		( ICD-9 =	B; ICD-10 = AB	)	3	31a. Other		
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	34a. Diagnosis	s Code	e(s)	Α		C			Fee(s)		
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17	(Primary diag	nosis i	in " <b>A</b> ")	В		D		3	32. Total Fee	159.67	
35. Remarks											
<b>36.</b> I have been informed of the treatment plan and associated fees. I agree to be response	sible for all					=office; 22=O/P H			sures (Y or N)		
charges for dental services and materials not paid by my dental benefit plan, unless pr law, or the treating dentist or dental practice has a contractual agreement with my plan	rohibited by	00.1		_		rofessional Claims		,			
or a portion of such charges. To the extent permitted by law, I consent to your use and of my protected health information to carry out payment activities in connection with the	disclosure	40. Is	s Treatment fo	r Ortho	dontics?			41. Date App	pliance Placed	I (MM/DD/CCYY)	
X SIGNATURE ON FILE 11/28/201			No (Ski	p 41-42	Yes	(Complete 41-42	2)	3/22/201	6	,	
Patient/Guardian Signature Date	<u> </u>	42. N	Months of Trea	tment	43. Repla	cement of Prosti	hesis	44. Date of F	Prior Placemen	nt (MM/DD/CCYY)	
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me	e, directly		12		No [	Yes (Comple	te 44)				
to the below named dentist or dental entity.		45. T	reatment Res	ulting fr	om						
X SIGNATURE ON FILE 11/28/201	6		Occupat	tional ill	ness/injury	Auto	accide	ent	Other accider	nt	
Subscriber Signature Date			Date of Accider	,					7. Auto Accide	ent State	
<b>BILLING DENTIST OR DENTAL ENTITY</b> (Leave blank if dentist or dental entit submitting claim on behalf of the patient or insured/subscriber.)	ty is not					ATMENT LO					
48. Name, Address, City, State, Zip Code			nereby certify nultiple visits)			as indicated by eted.	date a	re in progress	(for procedur	es that require	
Kenneth M. Sadler, DDS and Associates, PA			, ,		·				10010010		
201 Charlois Boulevard		Χ_	Dr Debora Signed (Trea					11	/28/2016 Date		
Winston-Salem, NC 27103		54. N	NPI 14574			5	5. Lice	nse Number			
			Address, City, S			5	6a. Pro	ovider v Code 122	23X0400X		
49. NPI 50. License Number 51. SSN or TIN			Charlois Blv			L	, poorait	, 0040 122	2		
1144309410 4151 56-2132966			ston-Salem,	NC 27	103						
52. Phone Number (336) 331-3500 52a. Additional Provider ID		57. P	Phone Number (33	36) 33	1-3500	5	8. Addi Prov	tional ⁄ider ID			

MEADURE NORMATION   Properties   Project   Properties   Project	ADA American Dentai Ass	ociation <b>Dent</b>	ai Ciaim	ı Forn	n											
	HEADER INFORMATION															
POLICYHOLDERSUBSCRIBER INFORMATION   For Insurance Company Nerval in INST.	Type of Transaction (Mark all applicable boxe)	5)														
POLICYPROLERS/BUSICHERS INFORMATION   To income Company Need   183,	X Statement of Actual Services	Request for Predetermination	n/Preauthorizat	ion												
INSURANCE COMMAN/DENTAL BENEFIT PLAN INFORMATION	X EPSDT / Title XIX															
BYRD, CRYSTAL H   BOX GEORGE HEGE RD   CENTRETON NO. 27295-7064	2. Predetermination/Preauthorization Number				P	OLICYHOLI	DER/S	UBSCRIB	ER INFORMA	TION (F	For Insuran	ce Company N	lamed in #3)			
S. Containable Name, Address, City, State, Zo Code					12	2. Policyholder	/Subsc	riber Name (	Last, First, Midd	le Initial,	Suffix), Add	lress, City, Sta	te, Zip Code			
6. Coase of Birth (MMCDICCYY)   7. Genetics   15. Policyholder/Subscriber ID (SSN or IDN)	INSURANCE COMPANY/DENTAL BEN	EFIT PLAN INFORMAT	ION		٦.	DVDD CE	VOT	· A I L I								
EXEMPTION: N. C. 27295-7064   EXAMPTION: N. C. 27295-7064   13. Date of Simi (MMDDIOCOY)   14. Gender   15. Positionisto-disclascration in C. (SSN or IDN)   15. Positionisto-discration in C. (SSN or IDN)   15. Positionisto-disclascration in C	3. Company/Plan Name, Address, City, State, Zi	p Code				•			D							
Solice of Birth (MMDDCCYY)   14. Gender   15. Posignoside-ribus-describer () (SSN or IDR)	BLUE CROSS BLUE SHIELD O	F NC					_	_								
OS/16/1976	P O BOX 2100				'	LEXINGI	JIN, I	NC 2729	J-7 UU4							
Cheesian	WINSTON-SALEM, NC 27102				13	3. Date of Birth	(MM/E	DD/CCYY)	14. Gender	15.	Policyholde	er/Subscriber I	D (SSN or ID#)			
4. Detailed						05/16/197	'6		$\square^{M} X$	F W	1369548	35				
A Name of Policyholder/Guscatiker in #4 (Last, First, Middle Initials, Suffix)   A TIENT INFORMATION   18. (Pealstoning to Policyholder/Guscatiker ID (SSN or ID)	OTHER COVERAGE (Mark applicable box a	and complete items 5-11. If n	one, leave blank	c.)	16	6. Plan/Group I	Numbe	er '	17. Employer Na	me						
Second District (MMDDICCYY)   7. Gender   8. Policyhoder/Suberchier ID (SSN or IDH)   9. Part   9. Past/crip (NMDDICCYY)   7. Gender   8. Policyhoder/Suberchier ID (SSN or IDH)   22. Name (Last, Fist, Model header, Suffix, Advance, Sx, State, 2p Code   9. Past/crip (Number   10. Pastrict Reliable header)   9. Pastrict Reliable header   9. Pastrict Reliable   9. Pastrict R	4. Dental? Medical? (If	both, complete 5-11 for dent	al only.)		1	080960		F	RAI							
Control of Serie (MMODICCYY)   7. Cender   8. Policyholder/Rubscriber ID (SSN or IDI)   7. Cender   9. Plant Close, Number   10. Plant Close   10. Plant C	5. Name of Policyholder/Subscriber in #4 (Last,	First, Middle Initial, Suffix)			P/	ATIENT INF	ORM	ATION								
Collect of Birth (MMCD/CCYY)					18	8. Relationship	to Poli	icyholder/Sul	oscriber in #12 A	bove		19. Reserv	ed For Future			
9. Plans/Group Number	6. Date of Birth (MM/DD/CCYY) 7. Gender	8. Policyholder/Sub	scriber ID (SSN	or ID#)	1	Self	Sp	oouse X	Dependent Chi	ld 🔲	Other	Use				
Self   Spouls   Dependent   Other   SOURCE   Self   Spouls   Dependent   Other   SOURCE   SERION   SOURCE   Self   Spouls   Dependent   Other   Self   Spouls   Self   Spouls   Dependent   Other   Self   Spouls   Self   Spouls	м _	F			20	D. Name (Last,	First, N	Middle Initial,	Suffix), Address	s, City, St	tate, Zip Co	de				
11. Other Insurance Company/Dental Benefit Flan Name, Address, City, State, Zip Code   10.000	9. Plan/Group Number 10. Patien	t's Relationship to Person na	med in #5													
EXINGTON, NC 27295-7064	Self	Spouse Depe	endent Ot	her					)							
AUTHORIZATIONS   Control	11. Other Insurance Company/Dental Benefit Pla	an Name, Address, City, Stat	e, Zip Code		_		_	-								
AUTHORIZATIONS   Control																
RECORD OF SERVICES PROVIDED   24   Procedure Date   Act Angle Section   Control Se					21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assi					igned by Dentist)						
Part   Part						07/26/200	)1		M X	F 80	5087162	2871				
All productions   All produc	RECORD OF SERVICES PROVIDED				•											
MINIODICOYY	24 Procedure Date 25. Area 26. 27 Tooth Number(s) 28 Tooth 29 E					29a. Diag.	29b.		20	Danasistia	_		24 5			
2			Surface	Code		Pointer	Qty.		30.	Description	on		31. Fee			
3	1 11/28/2016			D8670				PERIOD	ORTHO TX	INSTA	ALLMEN	Т	206.25			
A	2															
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Record   Company   Compa	4															
7	5															
Solution   Solution	6															
Solution   Solution	7															
1	8															
3. Missing Teeth Information (Place an "X" on each missing tooth.)  1 2 3 4 5 6 7 8 9 9 10 11 12 13 14 15 16 34a. Diagnosis Code(s)  3. 2 31 30 29 28 27 26 25 24 23 22 21 20 19 8 8 7 (Primary diagnosis in "A")  3. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for definal 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.  2. SIGNATURE ON FILE  1.1/28/2016  2. Subscriber Signature  Date  1.1/28/2016  2. Subscriber Signature  Date  1.1/28/2016  2. Martin Slomaiss  3. ADiagnosis Code List Qualifier  (ICC-9 = B; ICD-10 = AB)  3. A Lognosis Code(s)  A	9															
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32 31 30 28 28 27 26 25 24 23 22 21 20 19 18 17   12 13 34 15 16   34. Diagnosis Code(s)   A	33. Missing Teeth Information (Place an "X" on e	ach missing tooth.)	34.	Diagnosis (	Code	List Qualifier		( ICD-9 =	B; ICD-10 = AB	)	(					
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, crite 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, crossent to your up any 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  11/28/2016  Subscriber Signature  11/28/2016  BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  16/40. Treatment Resulting from  Coccupational illness/injury Auto accident Control information to control of the patient or insured/subscriber.)  18/50. Treatment Resulting from  Coccupational illness/injury Auto accident Control information to control of the patient or insured/subscriber.)  18/50. Treatment Resulting from  Coccupational illness/injury Auto accident Control information Cont	1 2 3 4 5 6 7 8 9	10 11 12 13 14 1	15 16 34a	. Diagnosis	Code	e(s)	A		c			Fee(s)				
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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, to rethe treating dentits or dental practice has a contractual agreement with my plan prohibiting and or a portion of such charges. To the extent permitted by law, to 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 11/28/2016 Subscriber Signature D	35. Remarks															
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Available   Company   Co					38. P	Place of Treatm	ent -	11 (e.g. 11	=office; 22=O/P H	lospital)	39. Enclos	sures (Y or N)				
At Date Appliance Placed (MM/DD/CCYY)    At Date Appliance Placed (MM/DD/CCYY)   At Date of Protopolatics	law, or the treating dentist or dental practice ha	as a contractual agreement w	ith my plan prohi	biting all		(Use "Place of	of Service	ce Codes for P	rofessional Claims	s")						
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  BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  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  54. NPI 1790716421  55. License Number  56. Address, City, State, Zip Code  49. NPI  1144309410  49. NPI  1144309410  40. Date of Accident (MM/DD/CCYY)  417. Auto Accident  418. Date of Accident (MM/DD/CCYY)  418. Date of Accident (MM/DD/CCYY)  419. Date of Accident (MM/DD/CCYY)  419. Date of Accident (MM/DD/CCYY)  410. Date of Accident (MM/DD/CCYY)  410. Date of Accident (MM/DD/CCYY)  410. Date of Accident (MM/DD/CCYY)  411. Auto Accident of Mercident or insured/subscriber.  510. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.  511. Self-Call of the patient or insured/subscriber.  512. NPI  513. Self-Call of the patient or insured/subscriber.  514. NPI  517. Self-Call of the patient or insured/s					40. Is	s Treatment for	r Ortho	dontics?		4	41. Date App	pliance Placed	(MM/DD/CCYY)			
Patient/Guardian Signature Date  42. Months of Treatment 16 No Yes (Complete 44)  43. Replacement of Prosthesis 16 No Yes (Complete 44)  44. Date of Prior Placement (MM/DD/CCYY)  45. Treatment Resulting from  Coccupational illness/injury Auto 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.)  BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  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  49. NPI 1790716421 55. License Number 56. Address, City, State, Zip Code  49. NPI 1144309410  4151	l	• •		I		No (Skip	p 41-42	2) X Yes	(Complete 41-42	2)	3/10/201	6				
**X** SIGNATURE ON FILE 11/28/2016  **Subscriber Signature**  **BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  **BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  **BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  **BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  **BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  **BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  **BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  **BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  **BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)  **BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitting claim or insured/subscriber.)  **BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitted 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  **Signed (Treating Den	' '	Dat	te	[·	42. N	Months of Treat	tment	43. Repla	cement of Prosti	nesis 4	44. Date of F	Prior Placemer	nt (MM/DD/CCYY)			
to the below named dentist or dental entity.  X SIGNATURE ON FILE 11/28/2016 Subscriber Signature Date 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  45. Treatment Resulting from Occupational illness/injury Auto accident Other accident (MM/DD/CCYY) 47. Auto Accident State  47. Auto Accident State  48. Name, Address, City, State, Zip Code  Kenneth M. Sadler, DDS and Associates, PA 201 Charlois Boulevard Winston-Salem, NC 27103  49. NPI 150. License Number 4151  51. SSN or TIN 56. Address, City, State, Zip Code  49. NPI 1740716421  50. License Number 4151  51. SSN or TIN 56. 2132966	37. I hereby authorize and direct payment of the	dental benefits otherwise pa	vable to me. dir	ectly		16		No	Yes (Comple	te 44)						
SIGNATURE ON FILE 11726/2016 Subscriber Signature Date 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.)  ### Auto Accident State  ### Auto		derital perionic outerwise pa	tyable to me, and		45. T	reatment Resu	ulting fr	om								
Subscriber Signature  Date  46. Date of Accident (MW/DD/CCYY)  47. Auto Accident State  48. Name, Address, City, State, Zip Code  Kenneth M. Sadler, DDS and Associates, PA 201 Charlois Boulevard Winston-Salem, NC 27103  49. NPI 1144309410  41. Auto Accident State  46. Date of Accident (MW/DD/CCYY)  47. Auto Accident State  48. Date of Accident (MW/DD/CCYY)  47. Auto Accident State  48. Date of Accident (MW/DD/CCYY)  51. Increase Indicated by date are in progress (for procedures that require multiple visits) or have been completed.  X Dr. Martin Slominski Signed (Treating Dentist) Date  54. NPI 1790716421  55. License Number  56. Address, City, State, Zip Code Specialty Code Specialt	X SIGNATURE ON FILE	11	/28/2016			Occupat	tional ill	ness/injury	Auto	accident	t [	Other accide	nt			
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  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 56a. Provider Specialty Code 1223X0400X  49. NPI 144309410 50. License Number 51. SSN or TIN 56-2132966  50. License Number 51. SSN or TIN 56-2132966				—  -	46. D	Date of Accider	nt (MM/	DD/CCYY)			4	7. Auto Accide	ent State			
1	BILLING DENTIST OR DENTAL ENTIT	Y (Leave blank if dentist or	dental entity is n	ot .	TRE	ATING DEN	NTIST	AND TRE	ATMENT LO	CATIO	N INFORI	MATION				
Kenneth M. Sadler, DDS and Associates, PA 201 Charlois Boulevard Winston-Salem, NC 27103  **Ton Martin Slominski**  **Signed (Treating Dentist)**  **Dr. Martin Slominski**  **Signed (Treating Dentist)**  **Date**  **Signed (Treating Dentist)**  **Signed (Treating Dentist)**  **Date**  **Signed (Treating Dentist)**  **Date**  **Signed (Treating Dentist)**  **Signed (Treating Dentist)**  **Date**  **Signed (Treating Dentist)**  **Si	submitting claim on behalf of the patient or insur	ed/subscriber.)		ļ.	53. I	hereby certify	that the	e procedures	as indicated by	date are	in progress	(for procedur	es that require			
201 Charlois Boulevard Winston-Salem, NC 27103  **Signed (Treating Dentist)**  54. NPI 1790716421  55. License Number 56. Address, City, State, Zip Code  49. NPI 1144309410  **Signed (Treating Dentist)**  56. Aprovider Specialty Code 1223X0400X  201 Charlois Blvd Winston-Salem, NC 27103	48. Name, Address, City, State, Zip Code				n	nultiple visits)	or have	been compl	eted.							
201 Charlois Boulevard Winston-Salem, NC 27103  **Signed (Treating Dentist)**  54. NPI 1790716421  55. License Number  56. Address, City, State, Zip Code  49. NPI  1144309410  50. License Number  51. SSN or TIN  56-2132966  **Signed (Treating Dentist)**  54. NPI 1790716421  55. License Number  56a. Provider Specialty Code 1223X0400X  201 Charlois Blvd Winston-Salem, NC 27103		ites, PA			X	Dr. Martin	Slo	minski			11	/28/2016				
54. NPI   1790716421   55. License Number   56. Address, City, State, Zip Code   56a. Provider   Specialty Code   1223X0400X					^_											
49. NPI         50. License Number         51. SSN or TIN         201 Charlois Blvd Winston-Salem, NC 27103         56a. Provider Specialty Code 1223X0400X	vviristori-salem, NC 27 103			[	54. N	NPI 17907	1642	21	I .							
49. NPI       50. License Number       51. SSN or TIN       201 Charlois Blvd         1144309410       4151       56-2132966       Winston-Salem, NC 27103									5	6a. Provid	der Code 122	23X0400X				
1144303410	49. NPI 50. License N	umber 51. SSN	or TIN						٢	,						
52. Phone Number (336) 331-3500   52a. Additional Provider ID   57. Phone Number (336) 331-3500   58. Additional Provider ID   903HC	1144309410 4151	I	2966	[	Wins	ston-Salem, I	NC 27	103								
	52. Phone Number (336) 331-3500	52a. Additional Provider ID			57. P N	Phone Number (33	6) 33	1-3500	5	8. Additio Provid	onal ler ID 903	ВНС				

ADA American Dental Association® Dental Cla	aim For	m										
HEADER INFORMATION												
1. Type of Transaction (Mark all applicable boxes)												
X Statement of Actual Services Request for Predetermination/Preauth	norization											
X EPSDT / Title XIX												
2. Predetermination/Preauthorization Number		_						ance Company N				
		- 12	2. Policyholder	/Subsc	riber Name (I	_ast, First, Middle	Initial, Suffix), A	Address, City, Sta	te, Zip Code			
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		$\dashv$	CERNY, E	RNE	ST							
Company/Plan Name, Address, City, State, Zip Code     BLUE CROSS BLUE SHIELD OF NC		1	1742 MUE	DY (	CREEK F	ROAD						
P O BOX 2100			CLEMMO	NS, N	NC 27012	<u> </u>						
WINSTON-SALEM, NC 27102		13	3. Date of Birth	(MM/E	DD/CCYY)	14. Gender	15. Policyho	older/Subscriber II	D (SSN or ID#)			
			12/13/197	2	,	XMF	W13695	683	,			
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave	e blank.)	_	6. Plan/Group I		r 1	7. Employer Nam						
4. Dental? Medical? (If both, complete 5-11 for dental only.)	·	┪,	080960		F	RAI						
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		P/	ATIENT INF	ORM	ATION							
		18	8. Relationship	to Poli	cyholder/Sub	scriber in #12 Ab	ove		ed For Future			
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID	(SSN or ID#)	ightharpoons	Self	Sp	oouse X	Dependent Child	Other	Use				
MF		20	0. Name (Last,	First, N	Middle Initial,	Suffix), Address,	City, State, Zip	Code				
9. Plan/Group Number 10. Patient's Relationship to Person named in #5			CERNY, F									
Self Spouse Dependent	Other	_	1742 MUE									
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Coo	de		CLEMMOI	NS, N	NC 27012							
		21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assig						igned by Dentist)				
			06/01/200		55,0011)	X M F	1	•	griod by Borniot,			
RECORD OF SERVICES PROVIDED			00/01/2002									
24 Procedure Date 25. Area 26. 27 Tooth Number(c) 28 To	oth 29. Proc	edure	29a. Diag.	29b.								
(MM/DD/CCYY) of Oral Tooth Cavity System or Letter(s) Surface			ture 29a. Diag. 29b. 30. Description Qty.						31. Fee			
1 11/28/2016	D8670	)	PERIOD ORTHO TX INSTALLMENT						206.25			
2												
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8 9												
10												
33. Missing Teeth Information (Place an "X" on each missing tooth.)	34. Diagnosis	Code	List Qualifier		(ICD-9 =	B; ICD-10 = AB )		31a. Other				
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	34a. Diagnos		( )	A	(112	C		Fee(s)				
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17	(Primary diag	nosis i		В		 D		32. Total Fee	206.25			
35. Remarks												
AUTHORIZATIONS						NT INFORMAT						
36. I have been informed of the treatment plan and associated fees. I agree to be respor charges for dental services and materials not paid by my dental benefit plan, unless		38. P		_		=office; 22=O/P Ho		closures (Y or N)				
law, or the treating dentist or dental practice has a contractual agreement with my plat or a portion of such charges. To the extent permitted by law, I consent to your use an		40.1				rofessional Claims")			A.M.A.D.D. (0.0) 0.0			
of my protected health information to carry out payment activities in connection with t	his claim.	40. IS	s Treatment for No (Skip			(Complete 41-42)		•••	(MM/DD/CCYY)			
X SIGNATURE ON FILE 11/28/20: Patient/Guardian Signature Date	16	42 N	Months of Treat			cement of Prosthe	1 1 1		it (MM/DD/CCYY)			
		72.10	12	unent	No [	Yes (Complete		or r nor r lacemen	it (IVIIVII DD/OOTT)			
37. I hereby authorize and direct payment of the dental benefits otherwise payable to r to the below named dentist or dental entity.	ne, directly	45. T	reatment Resu	ulting fr	om							
X SIGNATURE ON FILE 11/28/20	16		Occupat	ional ill	ness/injury	Auto a	ccident	Other accider	nt			
Subscriber Signature Date		46. D	Date of Accider	nt (MM/	DD/CCYY)			47. Auto Accide	ent State			
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental ent	ity is not	TRE	ATING DEN	NTIST	AND TRE	ATMENT LOC	ATION INFO	RMATION				
submitting claim on behalf of the patient or insured/subscriber.)							ate are in progr	ess (for procedure	es that require			
48. Name, Address, City, State, Zip Code		m	nultiple visits) o	or nave	been comple	etea.						
Kenneth M. Sadler, DDS and Associates, PA 201 Charlois Boulevard		Χ_	Dr. Martin					11/28/2016				
Winston-Salem, NC 27103		F	Signed (Treat			 	Line N	Date				
			NPI 17907				License Number					
40 NDI			Address, City, S		ib Code	Sp	ecialty Code 1	223X0400X				
49. NPI 50. License Number 51. SSN or TIN 1144309410 4151 56-2132966			Charlois Blvo ston-Salem, I		103							
52. Phone (226) 224 2500   52a. Additional		57. P	Phone (22		1-3500	58.	Additional Provider ID 9	USHC				
Number (336) 33 I-3300 Provider ID		N	<sub>Number</sub> (၁၁	<i>0)</i> 33	1-0000		Provider ID 9	UJIIU				

ADA American Dental Association® Dental C	Claim For	m										
HEADER INFORMATION												
1. Type of Transaction (Mark all applicable boxes)												
X Statement of Actual Services Request for Predetermination/Prea	authorization											
X EPSDT / Title XIX		┵										
2. Predetermination/Preauthorization Number		- ⊢				ER INFORMAT						
		— 12	Policyholder	/Subsc	riber Name (I	_ast, First, Middle	Initial, Suffix), A	ddress, City, Sta	te, Zip Code			
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		<b> </b>	HOLDEN,	WES	SLEY							
Company/Plan Name, Address, City, State, Zip Code     BLUE CROSS BLUE SHIELD OF NC		-   -	157 W VE	RNO	N CHUR	CH RD						
P O BOX 2100		-   '	WINSTON	I-SAL	_EM, NC	27107						
WINSTON-SALEM, NC 27102		13	3. Date of Birth	(MM/E	DD/CCYY)	14. Gender	15. Policyho	Ider/Subscriber II	D (SSN or ID#)			
			12/11/197	•	,	X M DF	'		,			
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, le	eave blank.)	_	6. Plan/Group I		r 1	7. Employer Nam						
4. Dental? Medical? (If both, complete 5-11 for dental only	.)	1	080960		F	RAI						
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		P.	ATIENT INF	ORM	ATION							
		18	8. Relationship	to Poli	icyholder/Sub	scriber in #12 Ab	ove		ed For Future			
6. Date of Birth (MM/DD/CCYY)  7. Gender  8. Policyholder/Subscribe	r ID (SSN or ID#)		Self	Sp	oouse X	Dependent Child	Other	Use				
MF		20	0. Name (Last,	First, N	Middle Initial,	Suffix), Address,	City, State, Zip (	Code				
9. Plan/Group Number 10. Patient's Relationship to Person named in			HOLDEN,									
Self Spouse Dependent		_	157 W VE									
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip	Code		WINSTON	I-SAL	LEM, NC 2	2/10/						
		21	1. Date of Birth	(MM/F	DD/CCYY)	22. Gender	23 Patient II	D/Account # (Assi	igned by Dentist)			
		11/28/2002 XM F 805057162869						•	griod by Borniot,			
RECORD OF SERVICES PROVIDED			17/20/2002									
24 Procedure Date 25. Area 26. 27 Tooth Number(s) 28	. Tooth 29. Pro	cedure	29a. Diag.	29b.								
	urface Co		Pointer	Qty.		30. D	escription		31. Fee			
1 11/28/2016	D867	0			PERIOD	ORTHO TX	NSTALLME	NT	199.58			
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3												
4												
5												
6												
9												
10												
33. Missing Teeth Information (Place an "X" on each missing tooth.)	34 Diagnosis	s Code	List Qualifier		(ICD-9 =	B; ICD-10 = AB )		31a, Other				
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16			1.7.	A	(112	С		Fee(s)				
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17	(Primary diag	gnosis	:- «A»\	В		 D		32. Total Fee	199.58			
35. Remarks												
AUTHORIZATIONS		-				NT INFORMAT						
36. I have been informed of the treatment plan and associated fees. I agree to be res charges for dental services and materials not paid by my dental benefit plan, unle		38. F		_		=office; 22=O/P Ho	· · · · · · · · · · · · · · · · · · ·	closures (Y or N)				
law, or the treating dentist or dental practice has a contractual agreement with my or a portion of such charges. To the extent permitted by law, I consent to your use		40.1				rofessional Claims")			/###/DD/00\00			
of my protected health information to carry out payment activities in connection w	ith this claim.	40. 19	Is Treatment for No (Skip			(Complete 41-42)			(MM/DD/CCYY)			
X SIGNATURE ON FILE 11/28/2 Patient/Guardian Signature Date	2016	42 N	Months of Treat			cement of Prosthe	101-11		it (MM/DD/CCYY)			
		'' ''	10	unone	No	Yes (Complete		or mor radomen	it (MINIBB/GGTT)			
37. I hereby authorize and direct payment of the dental benefits otherwise payable to the below named dentist or dental entity.	to me, directly	45. T	Treatment Resu	ulting fr	om							
X SIGNATURE ON FILE 11/28/2	2016	l	Occupat	ional ill	ness/injury	Auto a	ccident	Other accider	nt			
Subscriber Signature Date		46. E	Date of Acciden	nt (MM/	DD/CCYY)			47. Auto Accide	ent State			
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental	entity is not	TRE	EATING DEN	NTIST	AND TRE	ATMENT LOC	ATION INFO	RMATION				
submitting claim on behalf of the patient or insured/subscriber.)						as indicated by d	ate are in progre	ess (for procedure	es that require			
48. Name, Address, City, State, Zip Code		n	multiple visits) o	or have	been comple	eted.						
Kenneth M. Sadler, DDS and Associates, PA 201 Charlois Boulevard		X_	Dr. Martin					11/28/2016				
Winston-Salem, NC 27103		Signed (Treating Dentist)  Date										
		-	NPI 17907				License Numbe					
40 NDI	1	-	Address, City, S Charlois Blvo		ih code	Sp	ecialty Code 1	223X0400X				
49. NPI 50. License Number 51. SSN or TIN 414309410 4151 56-2132966			iston-Salem, N		103							
52. Phone (236) 224 2500   52a. Additional		57. F	Phone (33	6) 33	1-3500	58.	Additional 9	03HC				
Number (336) 331-3300 Provider ID		<u> </u>	Number (33	5, 55	. 5555		Provider ID 9	00110				

ADA American Dental Association® Dental Clai	im For	m							
HEADER INFORMATION									
1. Type of Transaction (Mark all applicable boxes)									
X Statement of Actual Services Request for Predetermination/Preauthor	ization								
X EPSDT / Title XIX		┸							
2. Predetermination/Preauthorization Number		_						rance Company N	
		→ <sup>12</sup>	2. Policyholder	r/Subsc	riber Name (	Last, First, Middle	Initial, Suffix), A	Address, City, Sta	te, Zip Code
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		-  ı	BARNES,	FRE	DERICK				
Company/Plan Name, Address, City, State, Zip Code     BLUE CROSS BLUE SHIELD OF NC			510 MAR		_				
P O BOX 2100		1	KERNER	SVILL	_E, NC 2	7284-9748			
WINSTON-SALEM, NC 27102		13	13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subs					older/Subscriber II	D (SSN or ID#)
			02/28/196	66	,	X M DF	1		,
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave b	lank.)	_	6. Plan/Group		er 1	7. Employer Nam		., 00	
4. Dental? Medical? (If both, complete 5-11 for dental only.)		1	080960		F	RAI			
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		P	ATIENT IN	FORM	ATION				
		18	18. Relationship to Policyholder/Subscriber in #12 Above 19. Reserve						
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (S	SSN or ID#)	L	Self	Sp	oouse X	Dependent Child	Other	Use	
MF		20	0. Name (Last	, First, N	Middle Initial,	Suffix), Address,	City, State, Zip	Code	
9. Plan/Group Number 10. Patient's Relationship to Person named in #5	1		BARNES,	CAM	IERON I				
Self Spouse Dependent	Other	_	510 MAR						
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code			KERNERS	SVILL	.E, NC 27	284-9748			
		21	1. Date of Birth	- (NANA/F	DD/CCVV)	22. Gender	23 Patient I	D/Account # (Ass	igned by Dentist)
			03/07/200		DD/CCTT)	X M F		•	igned by Dentist)
RECORD OF SERVICES PROVIDED			00/01/200			<u> </u>	000000		
24 Procedure Date 25. Area 26. 27 Tooth Number(s) 28 Tooth	29. Proc	edure	e 29a. Diag. 29b.						
(MM/DD/CCYY) of Oral Cavity System or Letter(s) Surface	Cod		e 29a, Diag. 29b. 30. Description						31. Fee
1 11/28/2016	D8670	)			PERIOD	ORTHO TX	INSTALLME	NT	199.58
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33. Missing Teeth Information (Place an "X" on each missing tooth.)	 34. Diagnosis	Code	List Qualifier		(ICD-9 =	B; ICD-10 = AB )		31a. Other	
	34a. Diagnosi			<u>Ш</u> А	(1000	C		Fee(s)	
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17	(Primary diag	nosis	in " <b>A</b> ")	В		 D		32. Total Fee	199.58
35. Remarks									
AUTHORIZATIONS		ANG	CILLARY CI	LAIM/	TREATME	NT INFORMAT	ГІОМ		
36. I have been informed of the treatment plan and associated fees. I agree to be responsit charges for dental services and materials not paid by my dental benefit plan, unless pro		38. F		_		=office; 22=O/P Ho		closures (Y or N)	
law, or the treating dentist or dental practice has a contractual agreement with my plan p or a portion of such charges. To the extent permitted by law, I consent to your use and or	rohibiting all					rofessional Claims")			
of my protected health information to carry out payment activities in connection with this	claim.	40. Is	s Treatment fo No (Ski			(Complete 41-42)			I (MM/DD/CCYY)
X SIGNATURE ON FILE 11/28/2016 Patient/Guardian Signature Date	<u> </u>	42 N	Months of Trea			cement of Prosthe	1-1-01		nt (MM/DD/CCYY)
		42. IV	14	ıımenı	No No	Yes (Complete		oi Piloi Piacemei	IL (IVIIVI/DD/CCTT)
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, to the below named dentist or dental entity.	, directly	45. T	Freatment Res	ulting fr		100 (00111)	,		
X SIGNATURE ON FILE 11/28/2016	,			-	ness/injury	Auto a	ccident	Other accide	nt
X SIGNATURE ON FILE 11/28/2016 Subscriber Signature Date		46. C	Date of Accide	nt (MM/	DD/CCYY)			47. Auto Accide	ent State
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity	is not	TRE	EATING DEI	NTIST	AND TRE	ATMENT LOC	ATION INFO	RMATION	
submitting claim on behalf of the patient or insured/subscriber.)							ate are in progr	ess (for procedur	es that require
48. Name, Address, City, State, Zip Code		n	nultiple visits)	or have	been compl	eted.			
Kenneth M. Sadler, DDS and Associates, PA		Х	Dr. Martin	Slo	minski			11/28/2016	
201 Charlois Boulevard Winston-Salem, NC 27103			Signed (Trea	iting De	ntist)			Date	
			NPI 17907				License Number		
[		56. Address, City, State, Zip Code Specialty Code 1223X0400X							
49. NPI 50. License Number 51. SSN or TIN 1144309410 4151 56-2132966			Charlois Blv ston-Salem,		103				
50 Phase			Dhana.			158	Additional	00110	
Sz. Phone Number (336) 331-3500 Sza. Additional Provider ID		N	Number (33	00) 33	1-3500		Additional Provider ID 9	บงทษ	

ADA American Dental Association® Dental C	laım Fori	m								
HEADER INFORMATION		$\Box$								
Type of Transaction (Mark all applicable boxes)  ———————————————————————————————————										
X Statement of Actual Services Request for Predetermination/Pread	uthorization									
X EPSDT / Title XIX										
2. Predetermination/Preauthorization Number						ER INFORMA		•		
		12. Poli	cyholder/s	Subsci	riber Name (l	_ast, First, Midd	lle Initial	l, Suffix), Addr	ess, City, Sta	te, Zip Code
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		→ MAE	BE, JEF	REM	Υ					
Company/Plan Name, Address, City, State, Zip Code     BLUE CROSS BLUE SHIELD OF NC		730	730 MT OLIVET CHURCH RD							
P O BOX 2100		LEX	LEXINGTON, NC 27295							
WINSTON-SALEM, NC 27102		13. Date	13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscribe						/Subscriber II	) (SSN or ID#)
		10/1	18/1974	4	,	XM	F N	v1369493	8	,
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, lea	ave blank.)		n/Group N		r 1	7. Employer Na				
4. Dental? Medical? (If both, complete 5-11 for dental only.)	)	080	960		F	RAI				
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		PATIE	NT INF	ORM	ATION					
		18. Rela	ationship t	to Poli	cyholder/Sub	scriber in #12 A	Above			ed For Future
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber	ID (SSN or ID#)		Self [	Sp	ouse X	Dependent Ch	ild 📗	Other	Use	
MF		20. Nan	ne (Last, I	First, N	/liddle Initial,	Suffix), Address	s, City, S	State, Zip Cod	е	
9. Plan/Group Number 10. Patient's Relationship to Person named in			BE, OL							
Self Spouse Dependent	Other		_		CHURC					
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip C	Code	LEX	INGIC	JN, N	IC 27295					
		21 Date	e of Rirth	(MM/D	D/CCYY)	22 Gender	23	Patient ID/A	count # (Assi	aned by Dentist)
			21. Date of Birth (MM/DD/CCYY)   22. Gender   23. Patient ID/Accour   04/28/2003   M   X   F   805025162867							grica by Derition)
RECORD OF SERVICES PROVIDED										
24 Procedure Date 25. Area 26. 27 Tooth Number(s) 28	Tooth 29. Proce	edure 29a	re 29a, Diag. 29b.							
	ırface Code		Pointer Qty. 30. Description						31. Fee	
1 11/28/2016	D8670	)			PERIOD	ORTHO TX	INST	ALLMENT	•	206.25
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3										
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9										
10										
33. Missing Teeth Information (Place an "X" on each missing tooth.)	34. Diagnosis	Code List Q	ualifier		( ICD-9 = 1	B; ICD-10 = AB	)	3	1a. Other	
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	34a. Diagnosis	s Code(s)		A		c			Fee(s)	
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17	(Primary diagr	nosis in " <b>A</b> ")	) <sub>E</sub>	в		D		3:	2. Total Fee	206.25
35. Remarks										
<b>AUTHORIZATIONS</b> 36. I have been informed of the treatment plan and associated fees. I agree to be resp	onsible for all					=office; 22=O/P F			ures (Y or N)	
charges for dental services and materials not paid by my dental benefit plan, unles law, or the treating dentist or dental practice has a contractual agreement with my p	ss prohibited by					rofessional Claim		OO. ENGIOS		
or a portion of such charges. To the extent permitted by law, I consent to your use	and disclosure	40. Is Trea	tment for	Ortho	dontics?			41. Date App	liance Placed	(MM/DD/CCYY)
of my protected health information to carry out payment activities in connection wit  X SIGNATURE ON FILE 11/28/2			No (Skip			Complete 41-4	- 1	6/2/2015		<b>(</b>
Patient/Guardian Signature Date		42. Months	s of Treatr	ment		cement of Prost			rior Placemen	t (MM/DD/CCYY)
37. I hereby authorize and direct payment of the dental benefits otherwise payable to	o me. directly	6			No	Yes (Comple	ete 44)			
to the below named dentist or dental entity.	,	45. Treatm	ent Resu	Iting fr	om		·			
X SIGNATURE ON FILE 11/28/2	2016		Occupation	onal illi	ness/injury	Auto	acciden	nt	Other accider	nt
Subscriber Signature Date		46. Date of	f Accident	t (MM/	DD/CCYY)			47	7. Auto Accide	nt State
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental e submitting claim on behalf of the patient or insured/subscriber.)	entity is not	TREATIN	NG DEN	ITIST	AND TRE	ATMENT LO	CATIO	ON INFORM	IATION	
		53. I hereby certify that the procedures as indicated by date are in progress (for procedures that remultiple visits) or have been completed.						es that require		
48. Name, Address, City, State, Zip Code		·	,		·					
Kenneth M. Sadler, DDS and Associates, PA 201 Charlois Boulevard		χ Dr E						11/	/28/2016	
Winston-Salem, NC 27103	ŀ	Signed (Treating Dentist)         Date           54. NPI 1457441420         55. License Number								
	}	56. Address, City, State, Zip Code 56a. Provider Specialty Code 1223X0400X								
49. NPI 50. License Number 51. SSN or TIN		201 Charlois Blvd								
1144309410 4151 56-2132966		Winston-S			103					
52. Phone Number (336) 331-3500 52a. Additional Provider ID		57. Phone Number (336) 331-3500   58. Additional Provider ID								

ADA American Dental Association Denta	ai Ciaim i	-orm									
HEADER INFORMATION											
Type of Transaction (Mark all applicable boxes)											
X Statement of Actual Services Request for Predetermination	n/Preauthorization										
X EPSDT / Title XIX											
2. Predetermination/Preauthorization Number		F	POLICYHOLI	DER/S	UBSCRIB	ER INFORMA	TION (For I	Insurance Company N	amed in #3)		
		1	12. Policyholder	/Subsc	riber Name (	Last, First, Middl	e Initial, Suff	fix), Address, City, Stat	te, Zip Code		
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATI	ION		LAVACONI	A B 4 4							
3. Company/Plan Name, Address, City, State, Zip Code			LAWSON,								
BLUE CROSS BLUE SHIELD OF NC			6457 UNI\								
P O BOX 2100			KUKAL III								
WINSTON-SALEM, NC 27102		1	13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscriber						O (SSN or ID#)		
			06/06/197	'1		M X	F W143	398942			
OTHER COVERAGE (Mark applicable box and complete items 5-11. If no	ne, leave blank.)	1	16. Plan/Group I	Numbe	er 1	17. Employer Na	me				
4. Dental? Medical? (If both, complete 5-11 for denta	l only.)		008557			BCBS OF N	С				
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		F	PATIENT INF	ORM	ATION						
		1	18. Relationship	to Poli	icyholder/Sub	oscriber in #12 A	bove		ed For Future		
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subs	scriber ID (SSN or	ID#)	Self	Sp	pouse X	Dependent Chi	d Othe	er Use			
		2	20. Name (Last,	First, N	Middle Initial,	Suffix), Address	, City, State,	, Zip Code			
Plan/Group Number     10. Patient's Relationship to Person nar	med in #5		LAWSON,	RYI	FY						
Self Spouse Deper	ndent Other	r	6457 UNI\			KWAY					
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State		RURAL H	ALL,	NC 2704	5						
		2	21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account						gned by Dentist)		
			08/07/200	3		M X	F 8005	11162866			
RECORD OF SERVICES PROVIDED											
24. Procedure Date 25. Area 26. 27. Tooth Number(s)	28. Tooth 2	9. Procedure	re 29a, Diag. 29b.						04 5		
(MM/DD/CCYY) of Oral Tooth Cavity System or Letter(s)	Surface	Code	Pointer	Qty.		30. 1	Description		31. Fee		
1 11/28/2016	D	8670	PERIOD ORTHO TX INSTALLMENT					MENT	206.25		
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9											
10											
33. Missing Teeth Information (Place an "X" on each missing tooth.)	34. Dia	gnosis Code	e List Qualifier		( ICD-9 =	B; ICD-10 = AB	)	31a. Other			
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15	5 16 34a. Di	iagnosis Cod	de(s)	A		c		Fee(s)			
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18	3 17 (Prima	ry diagnosis	s in " <b>A</b> ")	В		D		32. Total Fee	206.25		
35. Remarks											
AUTHORIZATIONS		AN	ICILLARY CL	AIM/	TREATME	NT INFORMA	TION				
36. I have been informed of the treatment plan and associated fees. I agree to be			Place of Treatm	ent	11 (e.g. 11	=office; 22=O/P H	ospital) 39	Enclosures (Y or N)			
charges for dental services and materials not paid by my dental benefit plan law, or the treating dentist or dental practice has a contractual agreement wit			(Use "Place of	of Service	ce Codes for P	rofessional Claims	")				
or a portion of such charges. To the extent permitted by law, I consent to you of my protected health information to carry out payment activities in connect			Is Treatment for	r Ortho	dontics?		41. 🛭	Date Appliance Placed	(MM/DD/CCYY)		
	28/2016		No (Skip	41-42	2) X Yes	(Complete 41-42	3/1	11/2015			
Patient/Guardian Signature Date		42.	Months of Treat	tment	43. Repla	cement of Prosth	esis 44. D	Date of Prior Placemen	t (MM/DD/CCYY)		
37. I hereby authorize and direct payment of the dental benefits otherwise pay	vable to me direct	lv	3		No	Yes (Complet	e 44)				
to the below named dentist or dental entity.	rable to me, direct		Treatment Resu	ulting fr	rom						
Y SIGNATURE ON FILE 11/	28/2016		Occupat	ional ill	Iness/injury	Auto	accident	Other accider	nt		
X	A						46. Date of Accident (MM/DD/CCYY) 47. Auto Accident				
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or d	TRI	EATING DEN	NTIST	AND TRE	ATMENT LO	CATION IN	NFORMATION				
submitting claim on behalf of the patient or insured/subscriber.)	53.	I hereby certify	that the	e procedures	as indicated by	date are in p	progress (for procedure	es that require			
48. Name, Address, City, State, Zip Code		multiple visits)	or have	been compl	eted.						
Kenneth M. Sadler, DDS and Associates, PA		\	Dr. Martin	Slo	minski			11/28/2016			
201 Charlois Boulevard		^	Signed (Treat					Date			
Winston-Salem, NC 27103		54.	NPI 17907	1642	21	5	5. License Nu	umber			
			Address, City, S			50	6a. Provider pecialty Code	e 1223X0400X			
49. NPI 50. License Number 51. SSN c	or TIN	201	1 Charlois Blvd	t		٥	poordity Code				
1144309410 4151 56-2132		Win	nston-Salem, N	NC 27	103						
52. Phone Number (336) 331-3500   52a. Additional Provider ID		57.	Phone Number (33	6) 33	1-3500	58	B. Additional	<sub>D</sub> 903HC			
Transper v /   Flovider ID			TAULIDEI (	,			i iovidei IL				

ADA American Dental Association® Dental Claim For	<u>'m</u>					
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	POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #					
	12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Co	de				
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	HOWARD, DAVID P					
3. Company/Plan Name, Address, City, State, Zip Code	1611 JUBILEE TRAIL					
BLUE CROSS BLUE SHIELD OF NC P O BOX 2100	KERNERSVILLE, NC 27284					
WINSTON-SALEM, NC 27102	40 Data of Distr (AMA/DD/COVOV) A44 Country A55 Data to Idea/Outrosition ID (COM) or	104)				
WINGTON-GALLINI, NO 27 102	13. Date of Birth (MM/DD/CCYY)   14. Gender   15. Policyholder/Subscriber ID (SSN or 11/28/1966   X M F   W13694977	IU#)				
OTHER COVERAGE Made and other based and the form of 44 Known based based	11/28/1966					
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)  4. Dental?	080960 RAI					
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)	PATIENT INFORMATION					
o. Name of Folloyfolder/odusonises in #4 (Eds.) First, Middle finidal, Odiny)	18. Relationship to Policyholder/Subscriber in #12 Above 19. Reserved For Ful	ture				
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN or ID#)	Self Spouse X Dependent Child Other					
M F	20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code					
9. Plan/Group Number 10. Patient's Relationship to Person named in #5	HOWARD, DUNCAN P					
Self Spouse Dependent Other	1611 JUBILEE TRAIL					
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	KERNERSVILLE, NC 27284					
	21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assigned by D	entist)				
	06/27/2002   XM □F   802161162865					
RECORD OF SERVICES PROVIDED						
24. Procedure Date of Oral (MM/DD/CCYY) of Oral (Movement of Carlotte of Carlotte of Carlotte of Letter(s) (MM/DD/CCYY) Or Letter(s) (MM/DD/CCYY) Or Letter(s) (MM/DD/CCYY)  (MM/DD/CCYYY) (MM/DD/CCYYY) (MM/DD/CCYYY) (MM/DD/CCYY		ee				
1 11/28/2016 Cavity System 0 Eetter(s) Surface Co		99.58				
2	0   TENIOD ONTHO TA INGTALLIMENT	33.30				
3						
4						
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6						
7						
8						
9						
10						
33. Missing Teeth Information (Place an "X" on each missing tooth.)  34. Diagnosis	s Code List Qualifier (ICD-9 = B; ICD-10 = AB) 31a. Other Fee(s)					
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 34a. Diagnos	sis Code(s) A C					
	gnosis in "A") B D 32. Total Fee 1	99.58				
35. Remarks						
AUTHORIZATIONS	ANGULI ARV OLAIM/TREATMENT INFORMATION					
<b>AUTHORIZATIONS</b> 36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all	ANCILLARY CLAIM/TREATMENT INFORMATION  38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) 39. Enclosures (Y or N)					
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	(Use "Place of Service Codes for Professional Claims")					
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.	40. Is Treatment for Orthodontics?  41. Date Appliance Placed (MM/DD/	CCYY)				
X SIGNATURE ON FILE 11/28/2016	No (Skip 41-42) X Yes (Complete 41-42) 6/9/2014					
Patient/Guardian Signature Date	42. Months of Treatment 43. Replacement of Prosthesis 44. Date of Prior Placement (MM/DD	/CCYY)				
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly	13 No Yes (Complete 44)					
to the below named dentist or dental entity.	45. Treatment Resulting from					
X SIGNATURE ON FILE 11/28/2016	Occupational illness/injury Auto accident Other accident					
Subscriber Signature Date	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.)	TREATING DENTIST AND TREATMENT LOCATION INFORMATION					
	53. I hereby certify that the procedures as indicated by date are in progress (for procedures that re multiple visits) or have been completed.					
48. Name, Address, City, State, Zip Code						
Kenneth M. Sadler, DDS and Associates, PA 201 Charlois Boulevard	X Dr Deborah F Novak 11/28/2016					
Winston-Salem, NC 27103	Signed (Treating Dentist)         Date           54. NPI 1457441420         55. License Number					
	50 5 11					
49. NPI 50. License Number 51. SSN or TIN	56. Address, City, State, Zip Code Specialty Code 1223X0400X  201 Charlois Blvd					
1144309410 4151 56-2132966	Winston-Salem, NC 27103					
52. Phone Number (336) 331-3500   52a. Additional Provider ID	57. Phone Number (336) 331-3500   58. Additional Provider ID					
I HONGE ID	Number \ / /					

ADA American Dental Association Denta	ii Ciaim	Form							
HEADER INFORMATION									
Type of Transaction (Mark all applicable boxes)									
X Statement of Actual Services Request for Predetermination	/Preauthorizatio	on							
X EPSDT / Title XIX									
2. Predetermination/Preauthorization Number			POLICYHOLI	DER/S	UBSCRIB	ER INFORMA	TION (For Ins	urance Company N	lamed in #3)
			12. Policyholder	/Subsc	riber Name (	Last, First, Middle	e Initial, Suffix),	Address, City, Sta	te, Zip Code
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	ON		FLIDANIZO		DDEN				
3. Company/Plan Name, Address, City, State, Zip Code			EUBANKS 1140 REY			E DD			
BLUE CROSS BLUE SHIELD OF NC			KERNERS	_	_				
P O BOX 2100			NEKNEKS	VILL	LE, INC Z	1204			
WINSTON-SALEM, NC 27102		ľ	13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscrib						O (SSN or ID#)
			05/15/197	1		X M D	- W1369	4793	
OTHER COVERAGE (Mark applicable box and complete items 5-11. If nor	ne, leave blank.)	)	16. Plan/Group i	Numbe	er '	17. Employer Nar	ne		
4. Dental? Medical? (If both, complete 5-11 for dental	only.)		080960		F	RAI			
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)			PATIENT INF	ORM	ATION				
		ŀ	18. Relationship	to Poli	icyholder/Sul	oscriber in #12 Ab	oove	19. Reserv	ed For Future
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subsc	criber ID (SSN o	or ID#)	Self	Sp	oouse X	Dependent Chile	d Other	Use	
	·	1	20. Name (Last,	First, I	Middle Initial,	Suffix), Address,	City, State, Zip	Code	
Plan/Group Number     10. Patient's Relationship to Person name	ned in #5		EUBANKS	S. PA	YTON				
Self Spouse Depen	dent Oth	er	1140 REY			E DR			
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State,		KERNERS							
			21. Date of Birth	(MM/E	DD/CCYY)	22. Gender	23. Patient	ID/Account # (Assi	gned by Dentist)
			10/26/200	2	162864				
RECORD OF SERVICES PROVIDED									
24. Procedure Date 25. Area 26. 27. Tooth Number(s)	28. Tooth	29. Procedure	re 29a. Diag.	29b.					04 5
(MM/DD/CCYY) of Oral Cavity System or Letter(s)	Surface	Code	Pointer	Qty.		30. D	escription		31. Fee
1 11/28/2016		D8670	PERIOD ORTHO TX INSTALLMENT					ENT	206.25
2									
3									
4									
5									
6									
7									
8									
9									
10									
33. Missing Teeth Information (Place an "X" on each missing tooth.)	34. D	iagnosis Cod	de List Qualifier		( ICD-9 =	B; ICD-10 = AB )	1	31a. Other	
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15	16 34a. [	Diagnosis Co	ode(s)	A		c		Fee(s)	
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18	17 (Prim	ary diagnosi	is in " <b>A</b> ")	В		D		32. Total Fee	206.25
35. Remarks									
AUTHORIZATIONS		AN	NCILLARY CL	AIM/	TREATME	NT INFORMA	TION		
36. I have been informed of the treatment plan and associated fees. I agree to be			. Place of Treatm	ent	11 (e.g. 11	=office; 22=O/P Ho	ospital) 39. E	nclosures (Y or N)	
charges for dental services and materials not paid by my dental benefit plan, law, or the treating dentist or dental practice has a contractual agreement with			(Use "Place of	of Servi	ce Codes for P	rofessional Claims"	r)		
or a portion of such charges. To the extent permitted by law, I consent to you of my protected health information to carry out payment activities in connection			. Is Treatment for	r Ortho	dontics?		41. Date	e Appliance Placed	(MM/DD/CCYY)
	28/2016	···	No (Skip	41-42	2) X Yes	(Complete 41-42)	8/3/2	016	
Patient/Guardian Signature Date		42.	. Months of Treat	tment	43. Repla	cement of Prosth	esis 44. Date	e of Prior Placemen	t (MM/DD/CCYY)
37. I hereby authorize and direct payment of the dental benefits otherwise paya	able to me direc	ctly	20		No	Yes (Complete	e 44)		
to the below named dentist or dental entity.	able to me, and		. Treatment Resu	ulting fr	om				
X SIGNATURE ON FILE 11/2	28/2016		Occupat	ional ill	ness/injury	Auto a	accident	Other accider	nt
Subscriber Signature Date		46.	. Date of Accider	nt (MM/	DD/CCYY)			47. Auto Accide	nt State
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or de	t TR	REATING DEN	ITIST	AND TRE	ATMENT LO	CATION INF	ORMATION		
submitting claim on behalf of the patient or insured/subscriber.)							gress (for procedure	es that require	
48. Name, Address, City, State, Zip Code		multiple visits)	or have	been compl	eted.	, ,			
Kenneth M. Sadler, DDS and Associates, PA			Dr. Martin	SIA	mineki			11/28/2016	
201 Charlois Boulevard		^	Signed (Treat					Date	
Winston-Salem, NC 27103		54.	NPI 17907			55	i. License Numi	ber	
			. Address, City, S			56	Sa. Provider	1223X0400X	
49. NPI 50. License Number 51. SSN o	r TIN		11 Charlois Blvd			Sp	becially Code	1220/0400/	
1144309410 4151 56-2132			inston-Salem, I		103				
52. Phone (226) 224 2500   52a. Additional		57.	Phone (33	6) 33	1-3500	58	. Additional Provider ID	903HC	
Number (336) 331-3300 Provider ID			Number (33	., 55			riovidel ID		

ADA American Dental Association Dent	tai Ciaim	Form							
HEADER INFORMATION									
Type of Transaction (Mark all applicable boxes)									
X Statement of Actual Services Request for Predetermination	on/Preauthorization	on							
X EPSDT / Title XIX									
2. Predetermination/Preauthorization Number			POLICYHOL	DER/S	UBSCRIB	ER INFORMAT	ION (For Insur	ance Company N	lamed in #3)
			12. Policyholder	/Subsc	riber Name (	Last, First, Middle	Initial, Suffix), A	ddress, City, Sta	ite, Zip Code
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMAT	TION		14/11 1 14 14		DON				
3. Company/Plan Name, Address, City, State, Zip Code			WILLIAMS 1041 BRC			DB			
BLUE CROSS BLUE SHIELD OF NC			WINSTON	-					
P O BOX 2100			VIINSTON						
WINSTON-SALEM, NC 27102			13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscriber						D (SSN or ID#)
			08/09/197	'1		XMF	W13694	306	
OTHER COVERAGE (Mark applicable box and complete items 5-11. If r	none, leave blank.	.)	16. Plan/Group	Numbe	er 1	7. Employer Nam	ie		
4. Dental? Medical? (If both, complete 5-11 for den	tal only.)		080960		F	RAI			
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)			PATIENT INF	ORM	ATION		,		
			18. Relationship	to Poli	icyholder/Suk	oscriber in #12 Ab	ove	19. Reserv	ed For Future
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Sul	bscriber ID (SSN o	or ID#)	Self	S	pouse X	Dependent Child	Other	Use	
		,	20. Name (Last,	First, I	Middle Initial,	Suffix), Address,	City, State, Zip	Code	
Plan/Group Number	amed in #5		WILLIAMS	s. AU	ISTIN C				
Self Spouse Dep	endent Oth	ner	1041 BRC			OR			
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, Sta		WINSTON							
			21. Date of Birth	(MM/E	DD/CCYY)	22. Gender	23. Patient II	D/Account # (Ass	igned by Dentist)
			01/10/2001 XM F 80242916286						
RECORD OF SERVICES PROVIDED									
24. Procedure Date 25. Area 26. 27. Tooth Number(s)	28. Tooth	29. Procedu	ıre 29a. Diag.	29b.		20. D.			24 5
(MM/DD/CCYY) of Oral Tooth Cavity System or Letter(s)	Surface	Code	Pointer	Qty.		30. De	escription		31. Fee
1 11/28/2016		D8670	PERIOD ORTHO TX INSTALLMENT					NT	199.58
2									
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8									
9									
10									
33. Missing Teeth Information (Place an "X" on each missing tooth.)	34. 🗅	Diagnosis Co	de List Qualifier		( ICD-9 =	B; ICD-10 = AB )		31a. Other	
1 2 3 4 5 6 7 8 9 10 11 12 13 14	15 16 34a.	Diagnosis C	Code(s)	Α		C		Fee(s)	
32 31 30 29 28 27 26 25 24 23 22 21 20 19	18 17 (Prim	nary diagnos	sis in " <b>A</b> ")	В		D		32. Total Fee	199.58
35. Remarks									
AUTHORIZATIONS		A	NCILLARY CL	AIM/	TREATME	NT INFORMAT	ION		
36. I have been informed of the treatment plan and associated fees. I agree to			3. Place of Treatm	nent	11 (e.g. 11	=office; 22=O/P Hos	spital) 39. End	closures (Y or N)	
charges for dental services and materials not paid by my dental benefit pla law, or the treating dentist or dental practice has a contractual agreement w	vith my plan prohib	iting all	(Use "Place	of Servi	ce Codes for P	rofessional Claims")			
or a portion of such charges. To the extent permitted by law, I consent to y of my protected health information to carry out payment activities in conne			D. Is Treatment fo	r Ortho	dontics?		41. Date	Appliance Placed	(MM/DD/CCYY)
	1/28/2016		No (Ski	p 41-42	2) X Yes	(Complete 41-42)	1/21/20	016	
Patient/Guardian Signature Da	ite	42	2. Months of Trea	tment	43. Repla	cement of Prosthe	sis 44. Date	of Prior Placemer	nt (MM/DD/CCYY)
37. I hereby authorize and direct payment of the dental benefits otherwise payment.	avable to me. dire	ectly	13		No	Yes (Complete	44)		
to the below named dentist or dental entity.	ayable to me, and		5. Treatment Res	ulting fr	rom		<u> </u>		
X SIGNATURE ON FILE 1	1/28/2016		Occupat	tional ill	Iness/injury	Auto a	ccident	Other accide	nt
Subscriber Signature Da	46	46. Date of Accident (MM/DD/CCYY) 47. Auto Accide					ent State		
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or	ot <b>T</b>	REATING DE	NTIST	AND TRE	ATMENT LOC	ATION INFO	RMATION		
submitting claim on behalf of the patient or insured/subscriber.)	53	TREATING DENTIST AND TREATMENT LOCATION INFORMATION  53. I hereby certify that the procedures as indicated by date are in progress (for procedures the					es that require		
48. Name, Address, City, State, Zip Code			multiple visits)	or have	e been compl	eted.			
Kenneth M. Sadler, DDS and Associates, PA			x Dr. Martin	Slo	minski			11/28/2016	
201 Charlois Boulevard		X Dr. Martin Slominski 11/28/2016 Signed (Treating Dentist) Date							
Winston-Salem, NC 27103		54	4. NPI 17907	1642	21		License Numbe		
			56. Address, City, State, Zip Code S6a. Provider Specialty Code 1223X0400X						
49. NPI 50. License Number 51. SSN	l or TIN		01 Charlois Blvd			[ 35	, 0040		
1144309410 4151 56-213	32966	W	/inston-Salem, I	NC 27	103				
52. Phone Number (336) 331-3500   52a. Additional Provider ID		57	7. Phone Number (33	6) 33	1-3500	58.	Additional 9 Provider ID	03HC	
							ID		

$\sim$ r	<b>DA</b> American L	Jenta	ai As	SOCI	ation° <b>i</b>	Jenta	ai Ciair	n For	m								
HE	ADER INFORMATION	1															
1.	ype of Transaction (Mark a	all applic	able bo	xes)													
	X Statement of Actual Ser	vices		Requ	est for Predet	erminatio	n/Preauthoriz	ation									
<u> </u>	X EPSDT / Title XIX																
2. F	Predetermination/Preauthor	ization I	Number						- ⊢-				ER INFORMAT				
$\vdash$									$-1^{12}$	2. Policyholde	r/Subsc	riber Name (	Last, First, Middle	e Initial, Si	uffix), Add	ress, City, Sta	te, Zip Code
	SURANCE COMPANY					ORMAT	ION		┦,	JONES, J	ESSE	ΞM					
]3.	Company/Plan Name, Addr BLUE CROSS BLU			•					-	165 BRO	ADMO	OOR DRI	VE				
ı	P O BOX 2100	L 311	ILLD	OI INC	,				/	ADVANCE, NC 27006							
ı	WINSTON-SALEM	, NC 2	27102						13	13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Si					r/Subscriber II	D (SSN or ID#)	
ı										01/24/196		,	X M F	-   <sub>W1</sub> ₄	409292	23	,
नि	HER COVERAGE (Mar	k applic	able box	x and co	mplete items 5	5-11. If no	one, leave bla	nk.)	_	6. Plan/Group		r ′	17. Employer Nan				
4. [	Dental? Medica	11?		(If both,	complete 5-11	for denta	al only.)	<u> </u>	7	080960		ı	RAI				
5.1	Name of Policyholder/Subs	criber in	#4 (Las	st, First, l	Middle Initial,	Suffix)			P	ATIENT IN	FORM	ATION					
									18	18. Relationship to Policyholder/Subscriber in #12 Above 19. Reserved							ed For Future
6. [	Date of Birth (MM/DD/CCY)	Y)	7. Gend		8. Policyho	older/Sub	scriber ID (SS	N or ID#)		Self	Sp	oouse X	Dependent Child	d Ot	her	Use	
L			M	F					20	). Name (Last	, First, I	Middle Initial,	Suffix), Address,	City, Stat	e, Zip Coo	de	
9. Plan/Group Number 10. Patient's Relationship to Person named in #5  Self Spouse Dependent Other							Oth a ::		JONES, S			_					
							Jiner	_	165 BRO			VΕ					
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code									ADVANC	⊨, NC	2/006						
l									21	21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (						ccount # (Assi	igned by Dentist)
l										04/05/200		,	X M F		281162		g,,
RE	CORD OF SERVICES	PROV	IDED														
П	24. Procedure Date	25. Area	26.	27	7. Tooth Number	r(s)	28. Tooth	29. Prod	cedure	29a. Diag. 29b. 20 Description						24 5	
Ц	(MM/DD/CCYY)	of Oral Cavity	Tooth System		or Letter(s)		Surface	Cod	de	Pointer Qty. 30. Description						31. Fee	
1	11/28/2016							D8670	)			PERIOD	ORTHO TX	INSTAL	LMENT	Γ	180.00
2																	
3																	
4																	
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10																	
33.	Missing Teeth Information	Place a	n "X" or	n each m	issing tooth.)		34	. Diagnosis	Code	List Qualifier		( ICD-9 =	B; ICD-10 = AB )		3	31a. Other	
Г	1 2 3 4 5 6	3 7	8 9	9 10	11 12 13	14 1	5 16 34	a. Diagnos	is Code	e(s)	Α		C			Fee(s)	
	32 31 30 29 28 2	7 26	25 2	4 23	22 21 20	19 1	8 17 (F	rimary diag	gnosis	in " <b>A</b> ")	В		D		3	32. Total Fee	180.00
35.	Remarks																
L																	
-	THORIZATIONS  I have been informed of the	troatm	ont plan	and acce	oniated foos. I	agree to	ho rosponsible	for all	_				=office; 22=O/P Ho		20 Englos	sures (Y or N)	
30.	charges for dental services	and ma	iterials n	ot paid b	y my dental be	enefit plar	n, unless proh	bited by	30. F				rofessional Claims"		39. ETICIOS	sules (1 Ol N)	
ı	law, or the treating dentist of or a portion of such charge	s. To the	extent	permitted	d by law, I cons	sent to yo	ur use and dis	closure	40. Is	s Treatment fo	or Ortho	dontics?		41	Date Apr	oliance Placed	(MM/DD/CCYY)
l <sub>x</sub>	of my protected health info		-	out payn	nent activities i		tion with this o /28/2016	laim.		No (Ski			(Complete 41-42)	- 1	/7/2014		· (······-
	Patient/Guardian Signature		ILL			Date			42. N	Months of Trea	atment		cement of Prosthe				t (MM/DD/CCYY)
37	I hereby authorize and dire	oct navn	nent of t	he denta	I hanafits othe	nvise na	vahle to me	lirectly	ł	0		No	Yes (Complete	944)			
"	to the below named dentis				ii benents ourc	orwise pa	yable to me, c	incotty	45. T	reatment Res	ulting fr	om					
lχ	SIGNATURE	ONI	FILE			11.	/28/2016			Occupa	tional ill	ness/injury	Auto a	accident		Other accider	nt
	Subscriber Signature Date							46. D	ate of Accide	nt (MM/	DD/CCYY)			4	7. Auto Accide	ent 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.)						not	TRE	ATING DE	NTIST	AND TRE	ATMENT LOC	CATION	INFORM	MATION		
, , , , , , , , , , , , , , , , , , ,							53. I hereby certify that the procedures as indicated by date are in progress (for procedures multiple visits) or have been completed.					es that require					
	Name, Address, City, State enneth M. Sadler, DD			siatos	DΔ				l							1001	
	enneth M. Sadier, DD 11 Charlois Boulevard		A3500	nates,	. ^				X_	Dr. Martin					11	/28/2016 Date	
W	inston-Salem, NC 27	103							54. N	IPI 17907			55	. License	Number	Date	
									_							230100	
49.	NPI	50.	License	Number		51. SSN	or TIN		56. Address, City, State, Zip Code Specialty Code 1223X0400X  201 Charlois Blvd								
11	44309410	415			I .	56-213				ston-Salem,		103					
52.	Phone Number (336) 331-35	500			52a. Addition Provide	ial r ID			57. P	Phone lumber (33	36) 33	1-3500	58	. Addition	al 903	BHC	

ADA American Dental Association Dental (	Siaim Fori	m						
HEADER INFORMATION								
Type of Transaction (Mark all applicable boxes)								
X Statement of Actual Services Request for Predetermination/Pre	authorization							
X EPSDT / Title XIX								
2. Predetermination/Preauthorization Number		POLICYHO	LDER/S	UBSCRIB	ER INFORMAT	ION (For Insura	ance Company N	lamed in #3)
		12. Policyhold	er/Subsc	riber Name (	Last, First, Middle	Initial, Suffix), A	ddress, City, Sta	ite, Zip Code
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION				NINIETLL	0			
3. Company/Plan Name, Address, City, State, Zip Code		DELOAC 7470 CO	,					
BLUE CROSS BLUE SHIELD OF NC			-					
P O BOX 2100		FEAFFI	PFAFFTOWN, NC 27040					
WINSTON-SALEM, NC 27102		13. Date of Bir	13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscribe					
		07/29/19	71		XMF	W13695	675	
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, le	eave blank.)	16. Plan/Group	p Numbe	r 1	7. Employer Nam	ie		
4. Dental? Medical? (If both, complete 5-11 for dental only	y.)	080960		F	RAI			
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		PATIENT IN	IFORM	ATION				
		18. Relationsh	ip to Poli	icyholder/Sub	scriber in #12 Ab	ove	19. Reserv	ed For Future
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscribe	er ID (SSN or ID#)	Self	Sp	oouse X	Dependent Child	Other	Use	
	,	20. Name (Las	st, First, I	Middle Initial,	Suffix), Address,	City, State, Zip (	Code	
Plan/Group Number	in #5	DELOAC	H. TH	OMAS				
Self Spouse Dependen	t Other		-	REEK RO	AD			
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip	Code			NC 2704				
		21. Date of Bir	th (MM/E	DD/CCYY)	22. Gender	23. Patient II	D/Account # (Ass	igned by Dentist)
		04/16/20	02	62861				
RECORD OF SERVICES PROVIDED		_						
24. Procedure Date 25. Area 26. 27. Tooth Number(s) 2	8. Tooth 29. Proce	edure 29a. Diag.	29b.					04.5
	Surface Code		Qty.		30. De	escription		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.)	34. Diagnosis	Code List Qualifier	$\overline{\Box}$	( ICD-9 =	B; ICD-10 = AB )		31a. Other	
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 1				(11111	C		Fee(s)	
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 1	7 (Primary diag	nosis in "A")	В				32. Total Fee	206.25
35. Remarks	, , ,	,			<u></u>			200.20
AUTHORIZATIONS		ANCILLARY O	CLAIM/	TREATME	NT INFORMAT	ION		
36. I have been informed of the treatment plan and associated fees. I agree to be res		38. Place of Treat	ment	11 (e.g. 11	=office; 22=O/P Hos	spital) 39. End	closures (Y or N)	
charges for dental services and materials not paid by my dental benefit plan, unled law, or the treating dentist or dental practice has a contractual agreement with my		(Use "Plac	e of Servi	ce Codes for P	rofessional Claims")			
or a portion of such charges. To the extent permitted by law, I consent to your us of my protected health information to carry out payment activities in connection w	e and disclosure	40. Is Treatment	for Ortho	dontics?		41. Date A	Appliance Placed	(MM/DD/CCYY)
X SIGNATURE ON FILE 11/28/		No (S	kip 41-42	2) X Yes	(Complete 41-42)	10/24/2	2014	
Patient/Guardian Signature Date		42. Months of Tre	atment	43. Repla	cement of Prosthe			nt (MM/DD/CCYY)
-	A din Ali	0		No [	Yes (Complete			,
<ol> <li>I hereby authorize and direct payment of the dental benefits otherwise payable to the below named dentist or dental entity.</li> </ol>	to me, directly	45. Treatment Re	sulting fr	om				
   x	2016	Occup	ational ill	ness/injury	Auto a	ccident	Other accide	nt
X SIGNATURE ON FILE 11/28/ Subscriber Signature Date		46. Date of Accident (MM/DD/CCYY) 47. Auto Accident \$						ent State
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or denta	Lentity is not	TREATING DENTIST AND TREATMENT LOCATION INFORMATION						
submitting claim on behalf of the patient or insured/subscriber.)	ondry to not				as indicated by d			es that require
48. Name, Address, City, State, Zip Code		multiple visits					,	
Kenneth M. Sadler, DDS and Associates, PA		V Dr Marti	n Sla	mineki			11/28/2016	
201 Charlois Boulevard		χ Dr. Marti Signed (Tre					Date	
Winston-Salem, NC 27103		<sup>54. NPI</sup> 1790			55.	License Numbe		
	ŀ	56. Address, City			I .		223X0400X	
49. NPI 50. License Number 51. SSN or TIN		201 Charlois Bl			Spe	ecialty Code Ta	<u> </u>	•
1144309410 4151 56-2132966		Winston-Salem		103				
52. Phone (226) 224 2500   52a. Additional		57. Phone	36) 33	1-3500	58.	Additional Provider ID 90	03HC	
Number (336) 331-3300 Provider ID		Number (S	22,00	. 5555		Provider ID 3	J J I J	

ADA American Dental Association Dental Ci	aim Fori	m								
HEADER INFORMATION										
Type of Transaction (Mark all applicable boxes)										
X Statement of Actual Services Request for Predetermination/Preaut	horization									
X EPSDT / Title XIX										
Predetermination/Preauthorization Number		PC	OLICYHOLI	DER/S	UBSCRIB	ER INFORMA	TION (For	Insurance	Company N	amed in #3)
		12.	. Policyholder	/Subsc	riber Name (	Last, First, Middl	le Initial, Suf	ffix), Addre	ess, City, Sta	te, Zip Code
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		٦,	CLARK, M	10110	267					
3. Company/Plan Name, Address, City, State, Zip Code		- 1	295 CANY							
BLUE CROSS BLUE SHIELD OF NC		1 -	MOCKSVILLE, NC 27028							
P O BOX 2100		"	WOONOVILLE, NO 27020							
WINSTON-SALEM, NC 27102		13.	13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscri						Subscriber II	(SSN or ID#)
			08/19/197	0		M X	F W13	694802	2	
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave	e blank.)	16.	. Plan/Group I	Numbe	er 1	7. Employer Na	me			
4. Dental? Medical? (If both, complete 5-11 for dental only.)			080960		F	RAI				
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		PA	ATIENT INF	ORM	ATION					
		18.	. Relationship	to Poli	icyholder/Sub	scriber in #12 A	bove			ed For Future
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber II	(SSN or ID#)	1	Self	Sp	oouse X	Dependent Chi	ld Oth	er	Use	
MF		20.	. Name (Last,	First, N	Middle Initial,	Suffix), Address	, City, State	, Zip Code	)	
9. Plan/Group Number 10. Patient's Relationship to Person named in #	5	$\exists$	CLARK, M	1ADE	LINE					
Self Spouse Dependent	Other		295 CANY							
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Co	de	_	MOCKSVI			8				
		21.	21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account						count # (Assi	gned by Dentist)
			06/04/200	)1		M X	F 8050	461628	360	
RECORD OF SERVICES PROVIDED										
24. Procedure Date 25. Area 26. 27. Tooth Number(s) 28. To	ooth 29. Proce	edure	29a. Diag.	29b.		20.1	Danasistias			24 5
(MM/DD/CCYY) of Oral Cavity System or Letter(s) Surface	ace Code	е	Pointer	Qty.		30. 1	Description			31. Fee
1 11/28/2016	D8670		PERIOD ORTHO TX INSTALLMENT						179.03	
2										
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8										
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10										
33. Missing Teeth Information (Place an "X" on each missing tooth.)	34. Diagnosis	Code L	List Qualifier		( ICD-9 =	B; ICD-10 = AB	)	31	a. Other	
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	34a. Diagnosi:	s Code	e(s)	A		C			Fee(s)	
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17	(Primary diag	nosis ir	n " <b>A</b> ")	В		D		32	. Total Fee	179.03
35. Remarks										
AUTHORIZATIONS		ANC	ILLARY CL	AIM/	TREATME	NT INFORMA	TION			
36. I have been informed of the treatment plan and associated fees. I agree to be respo		38. Pl	lace of Treatm	ent	11 (e.g. 11	=office; 22=O/P H	ospital) 39	9. Enclosu	res (Y or N)	
charges for dental services and materials not paid by my dental benefit plan, unless law, or the treating dentist or dental practice has a contractual agreement with my pla			(Use "Place of	of Service	ce Codes for P	rofessional Claims	;")			
or a portion of such charges. To the extent permitted by law, I consent to your use an of my protected health information to carry out payment activities in connection with		40. Is	Treatment for	r Ortho	dontics?		41. 1	Date Appli	ance Placed	(MM/DD/CCYY)
X SIGNATURE ON FILE 11/28/20			No (Skip	o 41-42	2) X Yes	(Complete 41-42	2) 8/2	26/2015		
Patient/Guardian Signature Date		42. M	lonths of Treat	tment	43. Repla	cement of Prosth	nesis 44. I	Date of Pri	ior Placemen	t (MM/DD/CCYY)
37. I hereby authorize and direct payment of the dental benefits otherwise payable to	me. directly		20		No	Yes (Complet	te 44)			
to the below named dentist or dental entity.	me, amouny	45. Tr	reatment Resu	ulting fr	om		'			
X SIGNATURE ON FILE 11/28/20	16		Occupati	ional ill	ness/injury	Auto	accident		Other accider	nt
Subscriber Signature Date	·	46. Da	ate of Acciden	nt (MM/	DD/CCYY)			47.	Auto Accide	nt State
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental en	tity is not	TRE	ATING DEN	NTIST	AND TRE	ATMENT LO	CATION I	NFORM	ATION	
submitting claim on behalf of the patient or insured/subscriber.)		53. I h	hereby certify	that the	e procedures	as indicated by	date are in	progress (	for procedure	es that require
48. Name, Address, City, State, Zip Code		mı	ultiple visits) o	or have	been compl	eted.				
Kenneth M. Sadler, DDS and Associates, PA		VГ	Dr. Martin	Slo	minski			11/	28/2016	
201 Charlois Boulevard		_ ` `—	Signed (Treat					1 1/.	Date	
Winston-Salem, NC 27103		54. NF	PI 17907	1642	21	5	5. License N	lumber		
			ddress, City, S			50	6a. Provider	le 1223	3X0400X	
49. NPI 50. License Number 51. SSN or TIN		56. Address, City, State, Zip Code Specialty Code 1223X0400X  201 Charlois Blvd								
1144309410 4151 56-2132966		Winst	ton-Salem, N	NC 27	103					
52. Phone Number (336) 331-3500 52a. Additional Provider ID		57. Ph	hone umber (33	6) 33	1-3500	58	8. Additional Provider I	<sub>D</sub> 903F	HC	
Transer v /   Floviderio		INI	uninci (-	,			i i ovideli l		-	

Al	<b>DA</b> American L	ent	al As	SOCI	ation"	Dent	ai Ciai	<u>m</u> ⊦or	m								
HE	EADER INFORMATION	ı															
1.	Type of Transaction (Mark all applicable boxes)  X Statement of Actual Services Request for Predetermination/Preauthorization																
1 5	<b>=</b>	vices		Requ	est for Prede	eterminatio	n/Preauthori	zation									
<u> </u>	X EPSDT / Title XIX																
2.1	Predetermination/Preauthor	ization l	Number										ER INFORMA		•		
$\vdash$									$-1^{12}$	2. Policyholde	r/Subsc	riber Name (	Last, First, Middle	e Initial	I, Suffix), Add	ress, City, Sta	ite, Zip Code
$\vdash$	SURANCE COMPANY					ORMAT	ION		-	HANELIN	E, RI	CKY G					
3.	Company/Plan Name, Addr BLUE CROSS BLU			•					:	200 MIDB	ROO	K RUN					
ı	P O BOX 2100	IE 311	IELD	OF IN	,					LEXINGTON, NC 27295-5616							
ı	WINSTON-SALEM	NC 2	27102						13	13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subsc						r/Subscriber II	D (SSN or ID#)
ı										09/14/195	58	ŕ	X M D	-	v1369367		,
07	THER COVERAGE (Mar	k applic	able bo	x and co	mplete items	5-11. If no	one, leave bl	ank.)	_	6. Plan/Group		er 1	17. Employer Nar				
4. 1	Dental? Medica	l?		(If both,	complete 5-1	1 for denta	al only.)		1	080960		F	RAI				
5. 1	Name of Policyholder/Subs	criber in	#4 (La:	st, First,	Middle Initial,	, Suffix)			P.	ATIENT IN	FORM	ATION					
ı									18	3. Relationship	to Poli	icyholder/Sub	oscriber in #12 Al	oove			ed For Future
6. 1	Date of Birth (MM/DD/CCY)	Y)	7. Gend	der	8. Policyh	older/Sub	scriber ID (S	SN or ID#)		Self	Sp	pouse X	Dependent Chil	d	Other	Use	
M F								20	). Name (Last	, First, I	Middle Initial,	Suffix), Address,	City, S	State, Zip Coo	le		
9. Plan/Group Number 10. Patient's Relationship to Person named in #5									HANELIN	,		;					
Self Spouse Dependent Other							Other	_	200 MIDB								
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code									LEXINGT	ON, N	NC 27295	-5616					
ı									21	1 Date of Birth	h (MM/F	DD/CCYY)	22. Gender	23	R Patient ID/A	ccount # (Assi	igned by Dentist)
ı									- 1	21. Date of Birth (MM/DD/CCYY)   22. Gender   23. Patient ID/Accour   06/26/2002   M   X   F   805050162859							ighted by Dentist)
RE	CORD OF SERVICES	PROV	IDED														
	24. Procedure Date	25. Area	26.	2	7. Tooth Number	er(s)	28. Tooth	29. Pro	cedure								
Ш	(MM/DD/CCYY)	of Oral Cavity			or Letter(s)	(-)	Surface	Co		Pointer Qty. 30. Description							31. Fee
1	11/28/2016							D867	0			PERIOD	ORTHO TX	INST	ALLMENT	Г	228.10
2																	
3																	
4																	
5																	
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8																	
9																	
10																	
33.	Missing Teeth Information	(Place a	n "X" or	n each m	nissing tooth.)	)	3	4. Diagnosis	Code	List Qualifier		(ICD-9 =	B; ICD-10 = AB )	)	3	1a. Other	
Г		3 7		9 10	11 12 1			4a. Diagnos			Α_		C	<u> </u>		Fee(s)	
	32 31 30 29 28 2	7 26	25 2	4 23	22 21 2	0 19 1	8 17 (	Primary dia	gnosis	in " <b>A</b> ")	В		D		3	2. Total Fee	228.10
35.	Remarks						'								'		
L																	
-	JTHORIZATIONS								-				NT INFORMA			04 10	
36.	I have been informed of the charges for dental services	and ma	iterials r	ot paid b	y my dental b	penefit plar	n, unless pro	nibited by	38. F		_		=office; 22=O/P Ho rofessional Claims'		39. Enclos	sures (Y or N)	
ı	law, or the treating dentist of or a portion of such charge	s. To the	extent	permitte	d by law, I cor	nsent to yo	ur use and d	isclosure	40.16	s Treatment fo			Totogotoriai Giairio		41 Date Apr	liance Placed	I (MM/DD/CCYY)
L	of my protected health info			out payr	nent activities		tion with this /28/2016		-0.1	No (Ski			(Complete 41-42	,	9/3/2015	marioe i lacea	(MINI/DD/0011)
Į×.	SIGNATURE Patient/Guardian Signature		FILE			Dat			42. N	Nonths of Trea			cement of Prosth	_		rior Placemen	nt (MM/DD/CCYY)
ᆫ	I hereby authorize and dire		oont of t	ho donte	l honofito oth	onuico no	vahla ta ma	directly	-	6		No [	Yes (Complete				,
31.	to the below named dentis				ai benenis ou	iei wise pa	yable to me,	directly	45. T	reatment Res	ulting fr	rom					
$ _{x}$	SIGNATURE	ON	FILE			11	/28/2016			Occupa	tional ill	Iness/injury	Auto a	accider	nt 🔲	Other accider	nt
	X SIGNATURE ON FILE 11/28/2016 Subscriber Signature Date							46. Date of Accident (MM/DD/CCYY) 47. Auto Accident \$						ent State			
	BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not						is not	TREATING DENTIST AND TREATMENT LOCATION INFORMATION									
submitting claim on behalf of the patient or insured/subscriber.)							53. I hereby certify that the procedures as indicated by date are in progress (for procedures that re multiple visits) or have been completed.						es that require				
48. Name, Address, City, State, Zip Code							Ι "	nunipie visits)	OI Have	been compr	eleu.						
	enneth M. Sadler, DD 01 Charlois Boulevard		Asso	ciates,	PA				X_	Dr Debor					11	/28/2016	
	inston-Salem, NC 27								54 1	Signed (Trea				Licon	nse Number	Date	
									-	NPI 14574						2004000	
49	NPI	50	License	Numbe	r	51. SSN	or TIN		56. Address, City, State, Zip Code Specialty Code 1223X0400X					•			
	44309410	41		ranibe		56-213				ston-Salem,		103					
52.	Phone Number (336) 331-35	500			52a. Additio Provide	nal			57. Phone Number (336) 331-3500   58. Additional Provider ID								

ADA American Dental Association® Dental C	laim For	m							
HEADER INFORMATION									
1. Type of Transaction (Mark all applicable boxes)									
X Statement of Actual Services Request for Predetermination/Preau	thorization								
X EPSDT / Title XIX		_							
Predetermination/Preauthorization Number		-				R INFORMAT			
		12. F	Policyholder/	/Subsci	riber Name (I	_ast, First, Middle	Initial, Suffix), A	ddress, City, Sta	te, Zip Code
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		⊣ м	OCK, W	AYNI	ΕH				
Company/Plan Name, Address, City, State, Zip Code     BLUE CROSS BLUE SHIELD OF NC		17	70 RIDGI	EWA	Y LN				
P O BOX 2100		LE	LEXINGTON, NC 27295						
WINSTON-SALEM, NC 27102		13 Г	13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subs						D (SSN or ID#)
			8/15/195	•	,,,,	X M F	1		5 (5511 511)
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leav	ve hlank )	_	Plan/Group N		r 1	7. Employer Nam		004	
4. Dental? Medical? (If both, complete 5-11 for dental only.)	ve blarik.)	_	80960	1411120		RAI			
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		PAT	TIENT INF	ORM	ATION				
		-				scriber in #12 Ab	ove	19. Reserv	ed For Future
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber II	D (SSN or ID#)		Self		. —	Dependent Child		Use	
	,	20. N	Name (Last,	First, N	Middle Initial,	Suffix), Address,	City, State, Zip (	Code	
9. Plan/Group Number 10. Patient's Relationship to Person named in #	<del>1</del> 5	М	10CK, RI	LEY	С				
Self Spouse Dependent	Other		70 RIDGI						
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Co	ode	LE	EXINGTO	ON, N	IC 27295				
		- 1	21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account						igned by Dentist)
		08	8/09/200	0		X MF	8005241	62858	
RECORD OF SERVICES PROVIDED			T., ., T.,						
24. Procedure Date of Oral Tooth (MM/DD/CCYY) 25. Area of Oral Tooth or Letter(s) 28. T			29a. Diag. Pointer	29b. Qty.		30. De	escription		31. Fee
1   11/28/2016	D8670	_	PERIOD ORTHO TX INSTALLMENT					NT	206.25
2	100070	<del>,</del>			FLIXIOD	OKTITO TX I	INSTALLIVIL	INI	200.23
3		$\dashv$							
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8		$\neg$							
9									
10									
33. Missing Teeth Information (Place an "X" on each missing tooth.)	34. Diagnosis	Code Lis	st Qualifier		( ICD-9 =	B; ICD-10 = AB )		31a. Other	
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	34a. Diagnosi	is Code(s	s)	Α		c		Fee(s)	
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17	(Primary diag	nosis in '	" <b>A</b> ")	В		D		32. Total Fee	206.25
35. Remarks									
AUTHORIZATIONS						NT INFORMAT			
36. I have been informed of the treatment plan and associated fees. I agree to be respondenced for dental services and materials not paid by my dental benefit plan, unless	prohibited by					office; 22=O/P Hos rofessional Claims")	spital) 39. End	closures (Y or N)	
law, or the treating dentist or dental practice has a contractual agreement with my pla or a portion of such charges. To the extent permitted by law, I consent to your use a						olessional Cialins )	44 D-4-	Name	(MMA/DD/00)(0/)
of my protected health information to carry out payment activities in connection with		40. IS T	Freatment for No (Skip			Complete 41-42)			(MM/DD/CCYY)
X SIGNATURE ON FILE 11/28/20 Patient/Guardian Signature Date	716	42 Mor	nths of Treat			cement of Prosthe	4/15/20		it (MM/DD/CCYY)
-		42. 10101	4	unent	No No	Yes (Complete		or Filor Flacemen	it (WIW/DD/CC11)
37. I hereby authorize and direct payment of the dental benefits otherwise payable to to the below named dentist or dental entity.	me, directly	45. Trea	atment Resu	ultina fr			,		
x SIGNATURE ON FILE 11/28/20	116	Г		-	ness/injury	Auto a	ccident [	Other accider	nt
X SIGNATURE ON FILE 11/28/20 Subscriber Signature Date		46. Dat	te of Acciden	nt (MM/	DD/CCYY)		L	47. Auto Accide	ent State
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental er	ntity is not	TREA	TING DEN	ITIST	AND TRE	ATMENT LOC	ATION INFO	RMATION	
submitting claim on behalf of the patient or insured/subscriber.)		53. I he	ereby certify	that the	e procedures	as indicated by d	ate are in progre	ess (for procedure	es that require
48. Name, Address, City, State, Zip Code		mul	Itiple visits) o	or have	been comple	eted.			
Kenneth M. Sadler, DDS and Associates, PA		x D	r. Martin	Slo	minski			11/28/2016	
201 Charlois Boulevard Winston-Salem, NC 27103		· '—	Signed (Treat					Date	
Trinistori Guiorii, 110 27 100			17907				License Numbe		
		56. Address, City, State, Zip Code Specialty Code 1223X0400X							
49. NPI 50. License Number 51. SSN or TIN		201 Charlois Blvd Winston-Salem, NC 27103							
1144309410 4151 56-2132966						1.50	Additional		
52. Phone Number (336) 331-3500 52a. Additional Provider ID		57. Phone Number (336) 331-3500   58. Additional Provider ID 903HC							

ADA American Dental Association Denta	il Claim Fo	rm							
HEADER INFORMATION									
Type of Transaction (Mark all applicable boxes)									
X Statement of Actual Services Request for Predetermination/	Preauthorization								
X EPSDT / Title XIX									
2. Predetermination/Preauthorization Number		P	POLICYHOLI	DER/S	UBSCRIB	ER INFORMA	TION (For In	surance Company N	amed in #3)
		1	12. Policyholder	/Subsc	riber Name (	Last, First, Middl	e Initial, Suffix	x), Address, City, Stat	te, Zip Code
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	ON		\A/II       A <b>N</b> A C		WOTAL I	<b>-</b>			
3. Company/Plan Name, Address, City, State, Zip Code			WILLIAMS			3			
BLUE CROSS BLUE SHIELD OF NC						E			
P O BOX 2100			YADKINVILLE, NC 27055						
WINSTON-SALEM, NC 27102		1	13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscribe						(SSN or ID#)
			11/12/197	1		M X	F W1369	93825	
OTHER COVERAGE (Mark applicable box and complete items 5-11. If non	ie, leave blank.)	1	16. Plan/Group I	Numbe	r	17. Employer Na			
4. Dental? Medical? (If both, complete 5-11 for dental	only.)		080960			RAI			
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		P	PATIENT INF	ORM	ATION				
		1	18. Relationship	to Poli	cvholder/Sub	oscriber in #12 Al	bove	19. Reserve	ed For Future
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subsc	riber ID (SSN or ID#	_	Self		oouse X	Dependent Chil		Use	
			20. Name (Last,	First, I		Suffix), Address	, City, State, Z	Zip Code	
9. Plan/Group Number 10. Patient's Relationship to Person nam	ed in #5		WILLIAMS	. ΙΔΙ	SED M	,,	, ,,	•	
Self Spouse Dependent			420 FORD						
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State,	Zip Code		YADKINVI						
			,						
		2	21. Date of Birth	(MM/E	DD/CCYY)	22. Gender	23. Patier	nt ID/Account # (Assign	gned by Dentist)
			01/05/2001 XM F 805053162857						
RECORD OF SERVICES PROVIDED		_							
24 Procedure Date 25. Area 26. 27 Tooth Number(s)	28. Tooth 29. Pr	ocedure	29a. Diag.	29b.					
(MM/DD/CCYY) of Oral Tooth Cavity System or Letter(s)		ode	Pointer	Qty.		30. [	Description		31. Fee
1 11/28/2016	D86	70	PERIOD ORTHO TX INSTALLMENT					MENT	266.11
2									
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7									
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9									
10									
33. Missing Teeth Information (Place an "X" on each missing tooth.)	34 Diagnos	is Code	e List Qualifier		(ICD-9 =	B; ICD-10 = AB	١	31a. Other	
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15					(1000	C	/	Fee(s)	
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18			- i «A"\	^				32. Total Fee	266.11
35. Remarks	ii (i iiiidiy di	agriooio	, , , , , , , , , , , , , , , , , , ,	В		D			200.11
os. remaine									
AUTHORIZATIONS		ΙΔΝ	ICII I ARY CI	ΔIM/	TREATME	NT INFORMA	TION		
36. I have been informed of the treatment plan and associated fees. I agree to be	e responsible for all	-	Place of Treatm			=office; 22=O/P H		Enclosures (Y or N)	
charges for dental services and materials not paid by my dental benefit plan, law, or the treating dentist or dental practice has a contractual agreement with	unless prohibited by	1				rofessional Claims			
or a portion of such charges. To the extent permitted by law, I consent to your	r use and disclosure	_	Is Treatment for	r Ortho	dontics?		41. Da	ate Appliance Placed	(MM/DD/CCYY)
of my protected health information to carry out payment activities in connection	on with this claim. 28/2016		No (Skip			(Complete 41-42	.	25/2015	(
X SIGNATURE ON FILE 11/2 Patient/Guardian Signature Date	20/2010	42.1	Months of Treat			cement of Prosth		ate of Prior Placement	t (MM/DD/CCYY)
		4	6		No	Yes (Complet			. (
37. I hereby authorize and direct payment of the dental benefits otherwise paya to the below named dentist or dental entity.	able to me, directly	45	Treatment Resu	ıltina fr		(	/		
·	00/0046			-		Auto	accident	Other acciden	nt
X SIGNATURE ON FILE 11/2 Subscriber Signature Date	28/2016							nt State	
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or de	46. Date of Accident (MM/DD/CCYY) 47. Auto Accide  TREATING DENTIST AND TREATMENT LOCATION INFORMATION					ni otate			
submitting claim on behalf of the patient or insured/subscriber.)	ental entity is not	_						ogress (for procedure	s that require
48. Name, Address, City, State, Zip Code			multiple visits)				date are in pro	ogress (for procedure	es that require
Kenneth M. Sadler, DDS and Associates, PA		1	D 14 (	01				44/00/0040	
201 Charlois Boulevard		X	Dr. Martin Signed (Treat					11/28/2016 Date	
Winston-Salem, NC 27103		54 1	NPI 17907			54	5. License Nur		
			Address, City, S						
49. NPI 50. License Number 51. SSN or	TIN	4	Address, City, S 1 Charlois Blvo		.p code	S	pecialty Code	1223X0400X	
49. NPI 50. License Number 51. SSN or 1144309410 4151 56-2132			nston-Salem, N		103				
52. Phone (226) 224 2500   52a. Additional		57. F	Phone (22			1.58	B. Additional	003110	
Number (336) 331-3500 S2a. Additional Provider ID		1-11	Number (33	o) 33	1-3500		B. Additional Provider ID	9U3HC	

ADA American Dentai As	ssociation <b>Dent</b>	ai Ciaim	Form									
HEADER INFORMATION												
Type of Transaction (Mark all applicable bo	oxes)											
X Statement of Actual Services	Request for Predeterminatio	n/Preauthorization	on									
X EPSDT / Title XIX												
2. Predetermination/Preauthorization Number	r			POLICYHOLI	DER/S	UBSCRIB	ER INFORMAT	FION (For Inst	ırance Company N	lamed in #3)		
				12. Policyholder	/Subsc	riber Name (	Last, First, Middle	Initial, Suffix),	Address, City, Sta	te, Zip Code		
INSURANCE COMPANY/DENTAL BE	ENEFIT PLAN INFORMAT	ION		WILLIAMS	SON	CHRIST	INA					
3. Company/Plan Name, Address, City, State,	•			7644 PEN	,							
BLUE CROSS BLUE SHIELD	OF NC			CLEMMO								
P O BOX 2100	•						14. Gender					
WINSTON-SALEM, NC 27102	<u>2</u>			13. Date of Birth	older/Subscriber II	D (SSN or ID#)						
				04/16/197			M X F		5966			
OTHER COVERAGE (Mark applicable bo	<u>'</u>		.)	16. Plan/Group I	Numbe		17. Employer Nan	ne				
	(If both, complete 5-11 for denta	al only.)		080960 RAI								
5. Name of Policyholder/Subscriber in #4 (La	ast, First, Middle Initial, Suffix)			PATIENT INF					40 Danam	ad Can Cutura		
6. Date of Birth (MM/DD/CCYY) 7. Gend	dor la Bir I I I I I I	" 10 (00)		18. Relationship		icyholder/Sul pouse X	oscriber in #12 Ab Dependent Child		Use Use	ed For Future		
7. General M		scriber ID (SSN	or ID#)				Suffix), Address,		Codo			
	tient's Relationship to Person na		, ,			Sullix), Address,	City, State, Zip	Code				
Se		ner	LUCERO, 7644 PEN									
11. Other Insurance Company/Dental Benefit			CLEMMO			-8457						
	,				, •	· • · •						
			l	21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (A						igned by Dentist)		
				02/23/200	)1		M X F	805040	162856			
RECORD OF SERVICES PROVIDED							•	'				
24. Procedure Date 25. Area 26. of Oral Tooth	27. Tooth Number(s)	28. Tooth	29. Procedu									
(MM/DD/CCYY) Cavity System		Surface	Code	Polities Qty.						31. Fee		
1 11/28/2016			D8670			PERIOD	ORTHO TX	INSTALLM	ENT	206.25		
2												
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4												
5												
6												
7												
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10												
33. Missing Teeth Information (Place an "X" or	un agab missing tooth \	24.5	Diagnosis Co	de List Qualifier		\ (ICD 0 =	B; ICD-10 = AB )		31a. Other			
	9 10 11 12 13 14 1		Diagnosis C			J (1CD-9 -	C		Fee(s)			
32 31 30 29 28 27 26 25 2			nary diagnos	-i- i- «A»\	A				32. Total Fee	206.25		
35. Remarks	20 22 21 20 10 1	0 17 (0 1111	nary diagnoc	JOIN A)	В		D		-   -   -	200.23		
AUTHORIZATIONS			A	NCILLARY CL	LAIM/	TREATME	NT INFORMA	ГІОН				
36. I have been informed of the treatment plan				3. Place of Treatm	nent [	11 (e.g. 11	l=office; 22=O/P Ho	spital) 39. E	nclosures (Y or N)			
charges for dental services and materials r law, or the treating dentist or dental practice	e has a contractual agreement wi	th my plan prohib	oiting all	(Use "Place of	of Servi	ce Codes for P	rofessional Claims"	)				
or a portion of such charges. To the extent of my protected health information to carry				). Is Treatment for	r Ortho			- 1	Appliance Placed	(MM/DD/CCYY)		
X SIGNATURE ON FILE	11/	/28/2016	L	No (Skip	p 41-42	2) X Yes	(Complete 41-42)	8/19/2	2015			
Patient/Guardian Signature	Dat	e	42	2. Months of Trea	tment	43. Repla	cement of Prosthe		of Prior Placemen	nt (MM/DD/CCYY)		
37. I hereby authorize and direct payment of t		yable to me, dire		8		No	Yes (Complete	9 44)				
to the below named dentist or dental entit	ty.		45	5. Treatment Resu	-							
X SIGNATURE ON FILE	_			Iness/injury	Auto a	ccident	Other accider					
Subscriber Signature	_	6. Date of Accider	,				47. Auto Accide	ent State				
BILLING DENTIST OR DENTAL ENT submitting claim on behalf of the patient or ins					ATMENT LOC			an that require				
48. Name, Address, City, State, Zip Code	——  <sup>53</sup>	53. I hereby certify that the procedures as indicated by date are in progress (for procedures that multiple visits) or have been completed.					es man require					
Kenneth M. Sadler, DDS and Associated												
201 Charlois Boulevard	- 1	X Dr. Martin Slominski 11/28/2016 Signed (Treating Dentist) Date										
Winston-Salem, NC 27103	54	54. NPI 1790716421 55. License Number										
		56. Address, City, State, Zip Code Specialty Code 1223X0400X										
49. NPI 50. License	49. NPI 50. License Number 51. SSN or TIN							201 Charlois Blvd				
1144309410 4151	56-213	2966	Winston-Salem, NC 27103									
52. Phone Number (336) 331-3500	52a. Additional Provider ID		57	57. Phone Number (336) 331-3500   58. Additional Provider ID 903HC								

ADA American Dental Association Dent	ai Ciaim	Form										
HEADER INFORMATION												
Type of Transaction (Mark all applicable boxes)												
X Statement of Actual Services Request for Predetermination	on/Preauthorization	ո										
X EPSDT / Title XIX												
2. Predetermination/Preauthorization Number		F	POLICYHOLI	DER/S	UBSCRIB	ER INFORMAT	ION (For Insur	rance Company N	Named in #3)			
		1	12. Policyholder	/Subsc	riber Name (	Last, First, Middle	Initial, Suffix),	Address, City, Sta	ite, Zip Code			
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMAT	TION			СТГ	-\ / N   A							
3. Company/Plan Name, Address, City, State, Zip Code			QUIGGLE 5885 COT			NI.						
BLUE CROSS BLUE SHIELD OF NC			WINSTON									
P O BOX 2100			WINSTON	I-SAL	_EIVI, INC	27 103						
WINSTON-SALEM, NC 27102		1	13. Date of Birth	(MM/E	DD/CCYY)	14. Gender	15. Policyho	older/Subscriber I	D (SSN or ID#)			
			06/01/195									
OTHER COVERAGE (Mark applicable box and complete items 5-11. If r	none, leave blank.)	1	06/01/1956									
4. Dental? Medical? (If both, complete 5-11 for den	tal only.)		081769 WIELAND COPPER PRODUCTS									
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		F	PATIENT INF	ORM	ATION							
		1	18. Relationship	to Poli	icyholder/Sul	oscriber in #12 Ab	ove		ed For Future			
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Sut	oscriber ID (SSN o	r ID#)	Self	Sp	oouse X	Dependent Child	Other	Use				
	2	20. Name (Last,	First, N	Middle Initial,	Suffix), Address,	City, State, Zip	Code					
Plan/Group Number		QUIGGLE	KAT	ΓIF .I								
Self Spouse Dep	er	5885 COT	•		N							
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, Sta		WINSTON										
		2	21. Date of Birth	D/Account # (Ass	igned by Dentist)							
			12/16/199	9		M X F	8050281	62855				
RECORD OF SERVICES PROVIDED												
24. Procedure Date 25. Area 26. 27. Tooth Number(s)	28. Tooth	29. Procedure	e 29a. Diag.	29b.		20.5			04.5			
(MM/DD/CCYY) of Oral Tooth Cavity System or Letter(s)	Surface	Code	Pointer	Qty.		30. D	escription		31. Fee			
1 11/28/2016		08670			PERIOD	ORTHO TX	INSTALLME	NT	206.25			
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10												
33. Missing Teeth Information (Place an "X" on each missing tooth.)	34. Dia	agnosis Code	e List Qualifier		( ICD-9 =	B; ICD-10 = AB )		31a. Other				
1 2 3 4 5 6 7 8 9 10 11 12 13 14	15 16 34a. D	iagnosis Cod	de(s)	A		c		Fee(s)				
32 31 30 29 28 27 26 25 24 23 22 21 20 19	18 17 (Prima	ary diagnosis	s in " <b>A</b> ")	В		D		32. Total Fee	206.25			
35. Remarks	'											
AUTHORIZATIONS		AN	ICILLARY CL	AIM/	TREATME	NT INFORMAT	TION					
36. I have been informed of the treatment plan and associated fees. I agree to			Place of Treatm	ent -	11 (e.g. 11	=office; 22=O/P Ho	spital) 39. En	closures (Y or N)				
charges for dental services and materials not paid by my dental benefit pla law, or the treating dentist or dental practice has a contractual agreement w	ith my plan prohibit	ing all	(Use "Place of	of Service	ce Codes for P	rofessional Claims")						
or a portion of such charges. To the extent permitted by law, I consent to y of my protected health information to carry out payment activities in conne			Is Treatment for	r Ortho	dontics?		41. Date	Appliance Placed	(MM/DD/CCYY)			
	/28/2016		No (Skip	41-42	2) X Yes	(Complete 41-42)	6/18/2	015				
Patient/Guardian Signature Da	te	42.	Months of Treat	tment	43. Repla	cement of Prosthe	esis 44. Date	of Prior Placemer	nt (MM/DD/CCYY)			
37. I hereby authorize and direct payment of the dental benefits otherwise pa	avable to me. direc	tlv	6		No	Yes (Complete	44)					
to the below named dentist or dental entity.	.,		Treatment Resu	ulting fr	om							
X SIGNATURE ON FILE 11	1/28/2016		Occupat	ional ill	ness/injury	Auto a	ccident	Other accide	nt			
Subscriber Signature Da	46.	46. Date of Accident (MM/DD/CCYY) 47. Auto Accident St										
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or	TR	EATING DEN	NTIST	AND TRE	ATMENT LOC	ATION INFO	RMATION					
submitting claim on behalf of the patient or insured/subscriber.)	53.	TREATING DENTIST AND TREATMENT LOCATION INFORMATION  53. I hereby certify that the procedures as indicated by date are in progress (for procedures that it						es that require				
48. Name, Address, City, State, Zip Code		multiple visits)	or have	been compl	eted.							
Kenneth M. Sadler, DDS and Associates, PA	\	Dr. Martin	Slo	minski			11/28/2016					
201 Charlois Boulevard	X Dr. Martin Slominski 11/28/2016 Signed (Treating Dentist) Date											
Winston-Salem, NC 27103	54. NPI 1790716421 55. License Number											
	56. Address, City, State, Zip Code Specialty Code 1223X0400X											
49. NPI 50. License Number 51. SSN	49. NPI 50. License Number 51. SSN or TIN							201 Charlois Blvd				
1144309410 4151 56-213	32966	Winston-Salem, NC 27103										
52. Phone Number (336) 331-3500   52a. Additional Provider ID		57.	57. Phone Number (336) 331-3500   58. Additional Provider ID 903HC									
i i i i i i i i i i i i i i i i i i i												

ADA American Dental Association® Dental Claim For	m						
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	POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)						
	12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code						
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	PRIERE DORERT						
3. Company/Plan Name, Address, City, State, Zip Code	PRIEBE, ROBERT 4807 TIFFANY AVE						
CIGNA	WINSTON SALEM. NC 27104						
PO BOX 188037	WINGTON SALLIVI, NO 27 104						
CHATTANOOGA, TN 37422-8037	13. Date of Birth (MM/DD/CCYY)  14. Gender  15. Policyholder/Subscriber ID (SSN or ID#)						
	09/22/1962 X <sup>M</sup> □ F U03809751						
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)	16. Plan/Group Number 17. Employer Name						
4. Dental? Medical? (If both, complete 5-11 for dental only.)	2499247 FEDEX						
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)	PATIENT INFORMATION						
	18. Relationship to Policyholder/Subscriber in #12 Above Use						
6. Date of Birth (MM/DD/CCYY)  7. Gender  8. Policyholder/Subscriber ID (SSN or ID#)	Self Spouse X Dependent Child Other						
MF	20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code						
9. Plan/Group Number 10. Patient's Relationship to Person named in #5	PRIEBE, MICHAEL A						
Self Spouse Dependent Other	234 HAVENWOOD DRIVE						
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	WINSTON SALEM, NC 27127-9050						
	21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assigned by Dentist)						
	06/29/2002 XM F 805052162854						
RECORD OF SERVICES PROVIDED							
24. Procedure Date (MM/DD/CCYY) 25. Area 26. Tooth (MM/DD/CCYY) 27. Tooth Number(s) 28. Tooth 29. Proc							
1 11/28/2016 D8670							
2	FEITIOD ORTHOTA INSTALLMENT 149.00						
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9							
10							
33. Missing Teeth Information (Place an "X" on each missing tooth.)  34. Diagnosis	s Code List Qualifier (ICD-9 = B; ICD-10 = AB) 31a. Other						
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 34a. Diagnos	is Code(s) A C						
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 (Primary diag	gnosis in "A") B D 32. Total Fee 149.68						
35. Remarks							
AUTHORIZATIONS	ANCILLARY CLAIM/TREATMENT INFORMATION						
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	38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) 39. Enclosures (Y or N)						
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	(Use "Place of Service Codes for Professional Claims")						
of my protected health information to carry out payment activities in connection with this claim.	40. Is Treatment for Orthodontics?  41. Date Appliance Placed (MM/DD/CCYY)						
X SIGNATURE ON FILE 11/28/2016	No (Skip 41-42) X Yes (Complete 41-42) 9/10/2015						
Patient/Guardian Signature Date	42. Months of Treatment 43. Replacement of Prosthesis 44. Date of Prior Placement (MM/DD/CCYY)						
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly	9 No Yes (Complete 44)						
to the below named dentist or dental entity.	45. Treatment Resulting from						
X SIGNATURE ON FILE 11/28/2016	Occupational illness/injury Auto accident Other accident						
Subscriber Signature Date	46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State						
<b>BILLING DENTIST OR DENTAL ENTITY</b> (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)	TREATING DENTIST AND TREATMENT LOCATION INFORMATION						
48. Name, Address, City, State, Zip Code	53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.						
Kenneth M. Sadler, DDS and Associates, PA	NA Da Daharah E Nasah						
201 Charlois Boulevard	X Dr Deborah F Novak 11/28/2016 Signed (Treating Dentist) Date						
Winston-Salem, NC 27103	54. NPI 1457441420 55. License Number						
	56. Address, City, State, Zip Code S6a. Provider Specialty Code 1223X0400X						
49. NPI 50. License Number 51. SSN or TIN	201 Charlois Blvd						
1144309410 4151 56-2132966	Winston-Salem, NC 27103						
52. Phone Number (336) 331-3500   52a. Additional Provider ID	57. Phone Number (336) 331-3500   58. Additional Provider ID						
I INDUIDEL / / I FIOVIDEL ID	FIGURE ID						

ADA American Dent	ai Associ	lation" <b>Dent</b>	ai Ciain	n Fori	m									
HEADER INFORMATION														
Type of Transaction (Mark all appli	cable boxes)													
X Statement of Actual Services	Req	uest for Predetermination	on/Preauthoriza	tion										
X EPSDT / Title XIX					L									
2. Predetermination/Preauthorization	Number				P	OLICYHOL	DER/S	UBSCRIB	ER INFORMA	TION (F	or Insuranc	e Company N	lamed in #3)	
					12	<ol><li>Policyholder</li></ol>	/Subsc	riber Name (	Last, First, Midd	le Initial, S	Suffix), Add	ress, City, Sta	te, Zip Code	
INSURANCE COMPANY/DEN	TAL BENEFI	F PLAN INFORMAT	TION		Π,	OXENDIN	E M	۸DV						
3. Company/Plan Name, Address, Ci	ty, State, Zip Co	de				1257 TER	,							
CIGNA						WINSTON			27107					
P O BOX 188037						VVIIVOTOIV	N-OAL	LLIVI, INC	21 101					
CHATTANOOGA, TN 37	7422				13	<ol><li>Date of Birth</li></ol>	(MM/E	DD/CCYY)	14. Gender	15. F	Policyholde	r/Subscriber II	D (SSN or ID#)	
						08/07/197	<b>'</b> 5		$\square$ M X	F U5	885967	2		
OTHER COVERAGE (Mark appli	cable box and c	omplete items 5-11. If n	one, leave blan	ık.)	16	16. Plan/Group Number 17. Employer Name								
4. Dental? Medical?	(If both	, complete 5-11 for dent	al only.)			3215072 KINDRED HEALTHCARE								
5. Name of Policyholder/Subscriber i	n #4 (Last, First	Middle Initial, Suffix)			P.	ATIENT INF	ORM	ATION						
					18	8. Relationship	to Poli	icyholder/Sul	oscriber in #12 A	bove			ed For Future	
6. Date of Birth (MM/DD/CCYY)	7. Gender	8. Policyholder/Sub	scriber ID (SSN	N or ID#)	1	Self	Sp	oouse X	Dependent Chi	ld C	Other	Use		
	MF				20	0. Name (Last,	First, N	Middle Initial,	Suffix), Address	s, City, Sta	ate, Zip Cod	le		
9. Plan/Group Number			CARTER,	СНА	NCELLO	R								
	ther		1257 TER			-								
11. Other Insurance Company/Denta		_	WINSTON			27107								
					21	21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Ass							igned by Dentist)	
						02/20/200	)2		X M	F 803	3130162	2853		
RECORD OF SERVICES PROV	VIDED													
24. Procedure Date 25. Are		27. Tooth Number(s)	28. Tooth	29. Proce	edure	29a. Diag.	29b.		20.1	Dagarintian	_		24 5	
(MM/DD/CCYY) of Oral	i   100tri	or Letter(s)	Surface	Code	е	Pointer	Qty.		30.1	Description	n		31. Fee	
1 11/28/2016				D8670	)			PERIOD	ORTHO TX	INSTA	ALLMENT	-	140.62	
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4														
5														
6														
7														
8														
9														
10														
33. Missing Teeth Information (Place	an "X" on each r	missing tooth.)	34.	Diagnosis	Code	List Qualifier		( ICD-9 =	B; ICD-10 = AB	)	3	1a. Other		
1 2 3 4 5 6 7	8 9 10	11 12 13 14	15 16 34	a. Diagnosis	s Cod	le(s)	A		c			Fee(s)		
32 31 30 29 28 27 26	25 24 23	22 21 20 19	18 17 (Pr	imary diagi	nosis	in " <b>A</b> ")	В		D		3	2. Total Fee	140.62	
35. Remarks														
AUTHORIZATIONS					ANG	CILLARY CI	AIM/	TREATME	NT INFORMA	ATION				
36. I have been informed of the treatm					38. F	Place of Treatm	ent -	11 (e.g. 11	=office; 22=O/P H	lospital)	39. Enclos	ures (Y or N)		
charges for dental services and m law, or the treating dentist or denta	al practice has a	contractual agreement w	ith my plan proh	nibiting all		(Use "Place	of Service	ce Codes for P	rofessional Claims	s")				
or a portion of such charges. To the of my protected health information					40. Is	s Treatment fo	r Ortho	dontics?		4	1. Date App	liance Placed	(MM/DD/CCYY)	
χ SIGNATURE ON			/28/2016			No (Ski	p 41-42	2) X Yes	(Complete 41-42	2) (	9/24/2014	4		
Patient/Guardian Signature		Da	te		42. N	Months of Trea	tment	43. Repla	cement of Prostr	nesis 4	4. Date of P	rior Placemen	t (MM/DD/CCYY)	
37. I hereby authorize and direct pay	ment of the dent	al benefits otherwise pa	avable to me. di	rectly		0		No	Yes (Complet	te 44)				
to the below named dentist or de		ai bononto otnor moo pe	tyabio to mo, ai	100.19	45. T	Treatment Res	ulting fr	om						
X SIGNATURE ON	FILE	11	/28/2016		Occupational illness/injury Auto accident Other accident						nt			
Subscriber Signature	— I	46. Date of Accident (MM/DD/CCYY) 47. Auto Accident S						ent State						
BILLING DENTIST OR DENTA	not	TRE	EATING DE	NTIST	AND TRE	ATMENT LO	CATION	N INFORM	MATION					
submitting claim on behalf of the pati	- 1	53. I	hereby certify	that the	e procedures	as indicated by	date are	in progress	(for procedure	es that require				
48. Name, Address, City, State, Zip Code						53. I hereby certify that the procedures as indicated by date are in progress (for procedures that multiple visits) or have been completed.					·			
Kenneth M. Sadler, DDS and Associates, PA						Dr Martin	Slo	minski			11	/28/2016		
201 Charlois Boulevard						X Dr. Martin Slominski 11/28/2016 Signed (Treating Dentist) Date								
Winston-Salem, NC 27103						54. NPI 1790716421 55. License Number								
						56. Address, City, State, Zip Code Specialty Code 1223X0400X								
49. NPI 50. License Number 51. SSN or TIN						201 Charlois Blvd								
	51	56-213		Winston-Salem, NC 27103										
52. Phone Number (336) 331-3500		52a. Additional Provider ID			57. Phone Number (336) 331-3500   58. Additional Provider ID 903HC									
NUMBER 1		I I TOVIGET ID			- 1	TAITING ("	,			TOVIDE	<u> </u>	-		

ADA American Dental Association De	entai Ciaim	ı Form	n							
HEADER INFORMATION			]							
Type of Transaction (Mark all applicable boxes)										
X Statement of Actual Services Request for Predeterm	ination/Preauthorizat	tion								
X EPSDT / Title XIX										
Predetermination/Preauthorization Number			POL	ICYHOLI	DER/S	UBSCRIB	ER INFORMAT	ION (For Insu	rance Company N	lamed in #3)
			12. P	Policyholder	/Subsc	riber Name (	Last, First, Middle	Initial, Suffix),	Address, City, Sta	te, Zip Code
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFOR	MATION		] <sub>TC</sub>	ORRES,	IOP	CE				
3. Company/Plan Name, Address, City, State, Zip Code						ONE RID	GELN			
CIGNA				_		EM. NC	_			
P O BOX 188037			L							
CHATTANOOGA, TN 37422			13. D	13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscriber						
			30	3/12/198	3		X M _ F	001710	352	
OTHER COVERAGE (Mark applicable box and complete items 5-1	1. If none, leave blani	k.)	16. Plan/Group Number 17. Employer Name							
4. Dental? Medical? (If both, complete 5-11 for	dental only.)		00	0058856	603	L	OWE'S CO	MPANIES,	, INC	
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suf	fix)		PAT	IENT INF	ORM	ATION				
			18. R	Relationship	to Poli	icyholder/Sub	scriber in #12 Ab	ove	19. Reserv	ed For Future
	r/Subscriber ID (SSN	l or ID#)		Self	Sp	oouse X	Dependent Child	Other	Use	
			20. N	Name (Last,	First, N	Middle Initial,	Suffix), Address,	City, State, Zip	Code	
9. Plan/Group Number 10. Patient's Relationship to Pers		TO	ORRES,	JAC	ОВ					
Self Spouse	ther	12	242 FOL	KSTO	ONE RIDO	GE LN				
11. Other Insurance Company/Dental Benefit Plan Name, Address, City		W	INSTON	I SAL	EM, NC	27127				
							22. Gender			
				Date of Birth	ID/Account # (Assi	igned by Dentist)				
			05	5/26/200	)2		X M F	805064	162852	
RECORD OF SERVICES PROVIDED										
24. Procedure Date (MM/DD/CCYY) 25. Area 26. of Oral Tooth (MM/DD/CCYY) 27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Proced Code	iure 2	29a. Diag. Pointer	29b. Qty.		30. D	escription		31. Fee
Cavity System	Guillace		+	PERIOD ORTHO TX INSTALLMENT						149.00
1 11/28/2016		D8670	_			PERIOD	ORTHO IX	NSTALLIVIE	=IN I	148.00
			_							
3			_							
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10	1								lat au	
33. Missing Teeth Information (Place an "X" on each missing tooth.)		Diagnosis C				( ICD-9 =	B; ICD-10 = AB )		31a. Other Fee(s)	
		ı. Diagnosis (		•	Α		c		32. Total Fee	
32 31 30 29 28 27 26 25 24 23 22 21 20 1	19 18 17 (Pri	mary diagno	osis in	Α)	В		D		. Sz. Total Fee	148.00
35. Remarks										
AUTHORIZATIONS		1,	ANCII	I ABV CI	A IBA/	TDEATME	NT INFORMAT	TION		
36. I have been informed of the treatment plan and associated fees. I agr	ee to be responsible t			ce of Treatm			=office; 22=O/P Ho		nclosures (Y or N)	
charges for dental services and materials not paid by my dental bene-	fit plan, unless prohib	ited by					rofessional Claims")			
law, or the treating dentist or dental practice has a contractual agreem or a portion of such charges. To the extent permitted by law, I consent	t to your use and disc	losure	10 Is Tr	reatment for	r Ortho	dontics?		41 Date	Appliance Placed	(MM/DD/CCYY)
of my protected health information to carry out payment activities in co	onnection with this cla 11/28/2016	aim.	TO: 13 11	No (Skip			(Complete 41-42)		,,	(WIWI/BB/COTT)
X SIGNATURE ON FILE Patient/Guardian Signature	Date	—   <sub>4</sub>	12 Mon	nths of Trea			cement of Prosthe	10,20,	of Prior Placemen	it (MM/DD/CCYY)
				16		No	Yes (Complete			
<ol> <li>I hereby authorize and direct payment of the dental benefits otherwi to the below named dentist or dental entity.</li> </ol>	se payable to me, dir		15. Trea		ultina fr		100 (00	,		
OLOMATURE ON EU E	11/28/2016		45. Treatment Resulting from  Occupational illness/injury  Auto accident  Other accident						nt	
X SIGNATURE ON FILE Subscriber Signature		46. Date of Accident (MM/DD/CCYY) 47. Auto Accident Sta							ent State	
BILLING DENTIST OR DENTAL ENTITY (Leave blank if denti	_	TREATING DENTIST AND TREATMENT LOCATION INFORMATION						Glato		
submitting claim on behalf of the patient or insured/subscriber.)	- ⊢	53. I hereby certify that the procedures as indicated by date are in progress (for procedures that						es that require		
48. Name, Address, City, State, Zip Code	$\longrightarrow$	53. I hereby certify that the procedures as indicated by date are in progress (for procedures that in multiple visits) or have been completed.								
Kenneth M. Sadler, DDS and Associates, PA		V. Dr. Martin Claminaki								
201 Charlois Boulevard		X Dr. Martin Slominski 11/28/2016 Signed (Treating Dentist) Date								
Winston-Salem, NC 27103	5	54. NPI 1790716421 55. License Number								
		56. Address, City, State, Zip Code Specialty Code 1223X0400X								
49. NPI 50. License Number 51.		201 Charlois Blvd								
	-2132966	Winston-Salem, NC 27103								
52. Phone Number (336) 331-3500 52a. Additional		5	7. Pho	ne (33	6) 33	1-3500	58.	Additional Provider ID	903HC	
Number (336) 331-3300 Provider ID			Nun	inner (20	-,			r rovider ID		

ADA American Dental Association® Dental Claim	im For	m									
HEADER INFORMATION											
1. Type of Transaction (Mark all applicable boxes)											
X Statement of Actual Services Request for Predetermination/Preauthor	ization										
X EPSDT / Title XIX											
2. Predetermination/Preauthorization Number		P	OLICYHOL	DER/S	UBSCRIB	ER INFORMA	FION (For Ins	urance Company N	amed in #3)		
		12	2. Policyholder	r/Subsc	riber Name (	Last, First, Middle	e Initial, Suffix),	Address, City, Stat	te, Zip Code		
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		_ ,	REDMON	D S/	ANDRA						
3. Company/Plan Name, Address, City, State, Zip Code			9015 BOB	,							
Cigna		_ I _ `	CHARLO1			6					
P O Box 188047						14. Gender					
Chattanooga, TN 37422			3. Date of Birth	older/Subscriber II	O (SSN or ID#)						
		_	01/18/197			M X		9737			
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave b	lank.)	_	16. Plan/Group Number 17. Employer Name								
4. Dental? Medical? (If both, complete 5-11 for dental only.)		_	10079347								
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		F	PATIENT INFORMATION								
		18			. –	oscriber in #12 Al		19. Reserve	ed For Future		
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (S	SSN or ID#)		Self			Dependent Chile		0-4-			
9. Plan/Group Number 10. Patient's Relationship to Person named in #5		_	` '		,	Suffix), Address,	City, State, Zip	Code			
Self Spouse Dependent	Other				,	RASHAWN					
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	_	9015 BOB CHARLO			3						
The other insurance company/bornal borleik Filah Hamile, Adalese, Oky, State, 219 code			OI I/ (I CLO)	∟, .	140 202 10	,					
		21	1. Date of Birth	ID/Account # (Assi	gned by Dentist)						
			04/23/199	96		X M	805083	162851			
RECORD OF SERVICES PROVIDED											
24 Procedure Date 25. Area 26. 27 Tooth Number(s) 28 Tooth	29. Proc	edure	29a. Diag.	29b.							
(MM/DD/CCYY) of Oral Tooth Cavity System or Letter(s) Surface	Cod	е	Pointer	Qty.		30. L	escription		31. Fee		
1 11/28/2016	D8670	)			PERIOD	ORTHO TX	INSTALLM	ENT	199.58		
2											
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8											
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10											
	34. Diagnosis			Ш	( ICD-9 =	B; ICD-10 = AB )		31a. Other Fee(s)			
	34a. Diagnosi		. ,	Α		с		32. Total Fee			
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 35. Remarks	(Primary diag	nosis i	in " <b>A</b> ")	В		D		- 32. Iotal Fee	199.58		
33. Remains											
AUTHORIZATIONS		ΔNC	CILLARY CI	LAIM/	TREATME	NT INFORMA	TION				
36. I have been informed of the treatment plan and associated fees. I agree to be responsit	ble for all					=office; 22=O/P Ho		nclosures (Y or N)			
charges for dental services and materials not paid by my dental benefit plan, unless pro law, or the treating dentist or dental practice has a contractual agreement with my plan p				_		rofessional Claims'	I .				
or a portion of such charges. To the extent permitted by law, I consent to your use and of my protected health information to carry out payment activities in connection with this	disclosure	40. Is	s Treatment fo	r Ortho	dontics?		41. Date	Appliance Placed	(MM/DD/CCYY)		
X SIGNATURE ON FILE 11/28/2016			No (Ski	p 41-42	2) X Yes	(Complete 41-42	) 1/20/:	2016			
Patient/Guardian Signature Date		42. N	Months of Trea	tment	43. Repla	cement of Prosth	esis 44. Date	e of Prior Placemen	t (MM/DD/CCYY)		
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me.	. directly		13		No	Yes (Complete	9 44)				
to the below named dentist or dental entity.	,	45. T	reatment Res	ulting fr	om						
X SIGNATURE ON FILE 11/28/2016	3	Occupational illness/injury Auto accident Other accident							nt		
Subscriber Signature Date		46. Date of Accident (MM/DD/CCYY) 47. Auto Accident Stat							nt State		
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity	is not	TRE	EATING DEI	NTIST	AND TRE	ATMENT LO	CATION INF	ORMATION			
submitting claim on behalf of the patient or insured/subscriber.)		53. I hereby certify that the procedures as indicated by date are in progress (for procedures that re multiple visits) or have been completed.						es that require			
48. Name, Address, City, State, Zip Code		"	nulliple visits)	or nave	been compi	etea.					
Kenneth M. Sadler, DDS and Associates, PA 201 Charlois Boulevard		X_	Dr. Martin					11/28/2016			
Winston-Salem, NC 27103		Signed (Treating Dentist)  Date									
		54. NPI 1790716421 55. License Number									
10 100		56. Address, City, State, Zip Code Specialty Code 1223X0400X									
49. NPI 50. License Number 51. SSN or TIN 1144309410 4151 56-2132966		201 Charlois Blvd Winston-Salem, NC 27103									
52. Phone (226) 224 2500   52a. Additional		57. Phone (236) 234 3500   58. Additional 003110									
Number (336) 331-3500 S2a. Additional Provider ID		. N	Number (33	00) 33	1-3500		Provider ID	9U3HC			

ADA American Dental Association® Dental Claim	Forn	n								
HEADER INFORMATION		]								
1. Type of Transaction (Mark all applicable boxes)										
X Statement of Actual Services Request for Predetermination/Preauthorization	on									
X EPSDT / Title XIX										
2. Predetermination/Preauthorization Number		P	OLICYHOL	DER/S	UBSCRIB	ER INFORMAT	TION (Fo	or Insurance	Company N	lamed in #3)
		12	2. Policyholde	r/Subsc	riber Name (	Last, First, Middle	Initial, S	uffix), Addre	ess, City, Sta	te, Zip Code
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		1.	THOMBS	ON 6	CHANNIC	.N.I				
3. Company/Plan Name, Address, City, State, Zip Code			THOMPS 145 STILL	,						
CIGNA			WINSTON							
P O BOX 188037		Ι,	VIIIVOTOI	N-0/1	LLIVI, INC	21 101				
CHATTANOOGA, TN 37422		13	13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscrit							D (SSN or ID#)
			03/20/197	77		X M F	⁼  U6′	1121222	<u>)</u>	
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank	<b>.</b> .)	16	16. Plan/Group Number 17. Employer Name							
4. Dental? Medical? (If both, complete 5-11 for dental only.)		L	2458462		1	MASS MUTU	JTAL F	FINANC	IAL	
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		P	ATIENT IN	FORM	ATION					
		18	3. Relationship	to Poli	cyholder/Sub	scriber in #12 Ab	ove		19. Reserv	ed For Future
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN	or ID#)	L	Self	Sp	oouse X	Dependent Child	d 0	ther	Use	
MF		20	). Name (Last	, First, I	Middle Initial,	Suffix), Address,	City, Stat	te, Zip Code	e	
9. Plan/Group Number 10. Patient's Relationship to Person named in #5			THOMPS	ON, J	ORDYN					
Self Spouse Dependent Oth	her	-1	145 STILL							
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code		'	WINSTON	N-SAL	EM, NC	27101				
		$\perp$								
			I. Date of Birtl		DD/CCYY)	22. Gender			-	igned by Dentist)
			03/01/200	)3		M X F	805	0931628	850	
RECORD OF SERVICES PROVIDED										
24. Procedure Date of Oral Tooth (MM/DD/CCYY) of Oral Tooth or Letter(s) Surface	29. Proced		e 29a. Diag. 29b. 30. Description							31. Fee
	D8670		1 onte	Giy.	DEDIOD	ORTHO TX	INICTAI	LINAENIT		140.62
2	D6670				PERIOD	OKINO IX	INSTAI	LLIVIENI		140.02
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	Diagnosis (	Code	List Qualifier		( ICD-9 =	B; ICD-10 = AB )		31	a. Other	
	Diagnosis			<u> </u>	(1000	C			Fee(s)	
	mary diagn		` '	В				32	. Total Fee	140.62
35. Remarks										140.02
AUTHORIZATIONS	1	ANC	CILLARY C	LAIM/	TREATME	NT INFORMAT	TION			
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for		38. P	Place of Treatn	nent	11 (e.g. 11	=office; 22=O/P Ho	spital)	39. Enclosu	ires (Y or N)	
charges for dental services and materials not paid by my dental benefit plan, unless prohibit law, or the treating dentist or dental practice has a contractual agreement with my plan prohib	biting all		(Use "Place	of Servi	ce Codes for P	rofessional Claims"	)			
or a portion of such charges. To the extent permitted by law, I consent to your use and discle of my protected health information to carry out payment activities in connection with this clai		40. Is	s Treatment fo	or Ortho	dontics?		41	. Date Appli	iance Placed	(MM/DD/CCYY)
X SIGNATURE ON FILE 11/28/2016	L		No (Ski	ip 41-42	Yes	(Complete 41-42)	4	/13/2016	i	
Patient/Guardian Signature Date	·	42. N	Nonths of Trea	atment	43. Repla	cement of Prosthe	esis 44	l. Date of Pri	ior Placemen	it (MM/DD/CCYY)
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, direct	ectly		16		No	Yes (Complete	944)			
to the below named dentist or dental entity.		45. T	reatment Res	ulting fr	om					
X SIGNATURE ON FILE 11/28/2016		Occupational illness/injury Auto accident Other accident						nt		
Subscriber Signature Date	· ·	46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State							ent State	
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is no submitting claim on behalf of the patient or insured/subscriber.)	ot .	TRE	ATING DE	NTIST	AND TRE	ATMENT LOC	CATION	INFORM	ATION	
, , , , , , , , , , , , , , , , , , , ,						as indicated by d	date are in	n progress (	for procedure	es that require
48. Name, Address, City, State, Zip Code		multiple visits) or have been completed.								
Kenneth M. Sadler, DDS and Associates, PA 201 Charlois Boulevard		χ_Dr Deborah F Novak 11/28/2016								
Winston-Salem, NC 27103	H	Signed (Treating Dentist)  Date  54 NPL 4457444400								
		54. NPI 1457441420 55. License Number 56. Address City State 7ip Code 56a. Provider 42020/04000								
40 ND		Specialty Code 1223X0400X								
49. NPI 50. License Number 51. SSN or TIN 1144309410 4151 56-2132966	201 Charlois Blvd Winston-Salem, NC 27103									
50 Phase		57. Phone (236) 234 2500   58. Additional								
Number (336) 331-3500 S2a. Additional Provider ID	[	N	lumber (33	33 (00	1-3500		Provide	r ID		

ADA American Der	itai As	SOCI	ation° <b>L</b>	Jenta	i Clair	n For	m									
HEADER INFORMATION																
Type of Transaction (Mark all ap	plicable bo	xes)														
X Statement of Actual Service	s [	Requ	est for Predete	ermination/	Preauthoriza	ation										
X EPSDT / Title XIX																
2. Predetermination/Preauthorization	on Numbe	•					P	OLICYHOL	DER/S	UBSCRIB	ER INFORM	ATION	l (For Insurar	nce Company N	lamed in #3)	
							12	2. Policyholder	r/Subsc	riber Name (	Last, First, Midd	dle Initia	al, Suffix), Ad	dress, City, Sta	ite, Zip Code	
INSURANCE COMPANY/DE	NTAL BI	NEFIT	PLAN INFO	ORMATIC	ON		٦,	CLARK, J.	۸۱/۸۵	<b>5</b>						
3. Company/Plan Name, Address,	City, State	, Zip Cod	е					4333 GRC			T C					
CIGNA							- 1	WINSTON								
P O BOX 188037								VVIIVOTOI	N-OAL	LLIVI, INC	21 103					
CHATTANOOGA, TN	37422						13	3. Date of Birth	n (MM/E	DD/CCYY)	14. Gender	15	5. Policyhold	er/Subscriber I	D (SSN or ID#)	
								10/13/197	76		XM	]F   L	J5226263	36		
OTHER COVERAGE (Mark ap	plicable bo	x and co	mplete items 5	5-11. If non	e, leave bla	nk.)	16	16. Plan/Group Number 17. Employer Name								
4. Dental? Medical?		(If both,	complete 5-11	for dental	only.)			2490738		(	CATERPIL	LAR				
5. Name of Policyholder/Subscribe	r in #4 (La	st, First, I	Middle Initial, S	Suffix)			P.	PATIENT INFORMATION								
							18	8. Relationship	to Poli	icyholder/Sul	bscriber in #12 /	Above			ed For Future	
6. Date of Birth (MM/DD/CCYY)	7. Gen	der	8. Policyhol	lder/Subsc	riber ID (SS	N or ID#)		Self	Sp	oouse X	Dependent Ch	ild	Other	Use		
MF								D. Name (Last,	, First, N	Middle Initial,	Suffix), Addres	s, City,	State, Zip Co	ode		
9. Plan/Group Number 10. Patient's Relationship to Person named in #5								ROBERTS	S, TA	MIA S						
Self Spouse Dependent Other								4333 GRC			С					
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code								WINSTON	N-SAL	EM, NC	27105					
							21	21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (A							igned by Dentist)	
								03/18/200	)1		M X	]F  8	0510016	2849		
RECORD OF SERVICES PR	OVIDED															
24. Procedure Date of C		27	7. Tooth Number(	r(s)	28. Tooth	29. Proc		29a. Diag.	29b.		30	Descript	tion		31. Fee	
(MM/DD/CCYY) Gra		<u> </u>	or Letter(s)		Surface	Cod	е	Pointer	Qty.		30.	Descripi	uon		31. Fee	
1 11/28/2016						D8670	)			PERIOD	ORTHO T	(INST	TALLMEN	IT	149.68	
2																
3																
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10																
33. Missing Teeth Information (Place	e an "X" o	n each m	issing tooth.)	·	34	. Diagnosis	Code	List Qualifier		( ICD-9 =	B; ICD-10 = AB	;)		31a. Other		
1 2 3 4 5 6	7 8	9 10	11 12 13	14 15	16 34	a. Diagnosi	s Cod	e(s)	Α		c			Fee(s)		
32 31 30 29 28 27 2	26 25 2	24 23	22 21 20	19 18	17 (P	rimary diag	nosis	in " <b>A</b> ")	В		D			32. Total Fee	149.68	
35. Remarks																
AUTHORIZATIONS							ANG	CILLARY CI	LAIM/	TREATME	NT INFORM	ATION				
<ol> <li>I have been informed of the trea charges for dental services and</li> </ol>							38. F	Place of Treatm			1=office; 22=O/P I		39. Enclo	sures (Y or N)		
law, or the treating dentist or der	ntal practice	e has a co	ontractual agree	ement with	my plan pro	hibiting all		(Use "Place	of Service	ce Codes for F	Professional Claim	s")				
or a portion of such charges. To of my protected health informati							40. Is	s Treatment fo	r Ortho	dontics?			41. Date Ap	opliance Placed	(MM/DD/CCYY)	
X SIGNATURE O	N FILE			11/2	28/2016			No (Ski	p 41-42	2) X Yes	(Complete 41-4	2)	5/10/20	16		
Patient/Guardian Signature				Date			42. N	Months of Trea	tment	43. Repla	cement of Prost	hesis	44. Date of	Prior Placemer	nt (MM/DD/CCYY)	
37. I hereby authorize and direct pa	ayment of	the denta	l benefits other	rwise paya	able to me, d	irectly		17		No	Yes (Comple	ete 44)				
to the below named dentist or o				. ,	,	ĺ	45. T	reatment Res	ulting fr	om						
X SIGNATURE O	N FILE			11/2	28/2016		Occupational illness/injury Auto accident Other accident						nt			
Subscriber Signature Date							46. Date of Accident (MM/DD/CCYY) 47. Auto Accident St						ent State			
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not							TREATING DENTIST AND TREATMENT LOCATION INFORMATION									
submitting claim on behalf of the patient or insured/subscriber.)							53. I hereby certify that the procedures as indicated by date are in progress (for procedures that						es that require			
48. Name, Address, City, State, Zip Code							multiple visits) or have been completed.									
Kenneth M. Sadler, DDS and Associates, PA							Х	Dr. Martin	Slo	minski			1	1/28/2016		
201 Charlois Boulevard Winston-Salem, NC 27103							Signed (Treating Dentist)  Date									
Winston-Salem, NC 27103							54. NPI 1790716421 55. License Number									
							56. Address, City, State, Zip Code Specialty Code 1223X0400X									
	49. NPI 50. License Number 51. SSN or TIN							201 Charlois Blvd								
	1151		I .	56-21329	966		Winston-Salem, NC 27103									
52. Phone Number (336) 331-3500   52a. Additional Provider ID								57. Phone Number (336) 331-3500   58. Additional Provider ID 903HC								

ADA American Dental Association® Dental Claim	ı Forr	n								
HEADER INFORMATION										
Type of Transaction (Mark all applicable boxes)										
X Statement of Actual Services Request for Predetermination/Preauthorization	ion									
X EPSDT / Title XIX										
2. Predetermination/Preauthorization Number		P	OLICYHOL	DER/S	UBSCRIB	ER INFORM	ATIO	<b>N</b> (For Insura	nce Company N	lamed in #3)
		12	2. Policyholder	r/Subsc	riber Name (	Last, First, Mid	dle Init	ial, Suffix), Ad	ddress, City, Sta	te, Zip Code
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		] ,	ALLEN, H	FΔTI	HER					
3. Company/Plan Name, Address, City, State, Zip Code			396 EAST							
CIGNA		_ I _ `	KING, NC							
P O BOX 188037		$\perp$								
CHATTANOOGA, TN 37422			13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscril							D (SSN or ID#)
		_	10/12/197			M X		10288110	64	
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank	k.)	_	16. Plan/Group Number 17. Employer Name							
4. Dental? Medical? (If both, complete 5-11 for dental only.)		┰	00745543 IMG WORLDWIDE							
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		-	ATIENT IN						1	
0.0 1. (0.11. (111/100/000) 7.0 1		18			_	scriber in #12	_		19. Reserv Use	ed For Future
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN	or ID#)		Self			Dependent Ch		Other		
9. Plan/Group Number 10. Patient's Relationship to Person named in #5		-	•			Suffix), Addres	ss, City	, State, Zip C	ode	
	her		ALLEN, S							
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code			396 EAST KING, NC							
The other insurance company/bornal borleik Flat Harris, Address, only, state, Elp code			raivo, ivo	2102	- '					
		21	21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Ass							igned by Dentist)
			12/02/200	)2		$\square$ M $\square$	]F	80510316	52848	
RECORD OF SERVICES PROVIDED										
24. Procedure Date 25. Area 26. 27. Tooth Number(s) 28. Tooth	29. Proce	edure	29a. Diag.	29b.		20	Danami			24 5
(MM/DD/CCYY) of Oral Cavity System or Letter(s) Surface	Code	•	Pointer	Qty.			. Descri	puori		31. Fee
1 11/28/2016	D8670				PERIOD	ORTHO T	X INS	STALLMEN	NT	199.58
2										
3										
4										
5										
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7										
8										
9										
									04-00-	
			List Qualifier		( ICD-9 =	B; ICD-10 = AE	3)		31a. Other Fee(s)	
	. Diagnosis mary diagr		. ,	Α		c			32. Total Fee	400.50
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 (Pring 35, Remarks	illaly ulayi	10515	III A)	В		D			SZ. TOTALT CC	199.58
AUTHORIZATIONS	Т	ANC	CILLARY CI	LAIM/	TREATME	NT INFORM	ATIO	N		
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for		38. P	Place of Treatm	nent	11 (e.g. 11	=office; 22=O/P	Hospita	il) 39. Encl	osures (Y or N)	
charges for dental services and materials not paid by my dental benefit plan, unless prohibi law, or the treating dentist or dental practice has a contractual agreement with my plan prohi	biting all		(Use "Place	of Servi	ce Codes for P	rofessional Clain	ns")			
or a portion of such charges. To the extent permitted by law, I consent to your use and discl of my protected health information to carry out payment activities in connection with this cla		40. Is	s Treatment fo	r Ortho	dontics?			41. Date A	ppliance Placed	(MM/DD/CCYY)
X SIGNATURE ON FILE 11/28/2016			No (Ski	ip 41-42	2) X Yes	(Complete 41-4	12)	4/14/20	16	
Patient/Guardian Signature Date		42. N	Months of Trea	tment	43. Repla	cement of Pros	thesis	44. Date of	f Prior Placemer	nt (MM/DD/CCYY)
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, direct	ectly		10		No	Yes (Compl	ete 44)			
to the below named dentist or dental entity.	- 1	45. T	reatment Res	-				_	_	
X SIGNATURE ON FILE 11/28/2016		Occupational illness/injury Auto accident Other accident								
Subscriber Signature Date		46. Date of Accident (MM/DD/CCYY) 47. Auto Accident Sta							ent State	
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is n submitting claim on behalf of the patient or insured/subscriber.)	- 1	TREATING DENTIST AND TREATMENT LOCATION INFORMATION								
, , , , , , , , , , , , , , , , , , ,		53. I hereby certify that the procedures as indicated by date are in progress (for procedures that multiple visits) or have been completed.						es that require		
48. Name, Address, City, State, Zip Code Kenneth M. Sadler, DDS and Associates, PA					·				4/00/00:5	
201 Charlois Boulevard		X_Dr. Martin Slominski 11/28/2016 Signed (Treating Dentist) Date								
Winston-Salem, NC 27103	ŀ	54. NPI 1790716421 55. License Number								
	ł	50.5.11								
49. NPI 50. License Number 51. SSN or TIN		56. Address, City, State, Zip Code Specialty Code 1223X0400X  201 Charlois Blvd								
1144309410 4151 56-2132966	Winston-Salem, NC 27103									
52. Phone Number (336) 331-3500   52a. Additional Provider ID		57. Phone Number (336) 331-3500   58. Additional Provider ID 903HC								
Trained , ,   Flovider ID		ı۱	TAILING!	,			<u> </u>	THUGH ID	-	

ADA Ameri	can De	enta	al As	SOCI	ation	Dent	ai Ciai	m For	m									
HEADER INFOR	MATION																	
Type of Transaction	n (Mark all a	applica	able box	xes)														
X Statement of A	Actual Servio	ces		Requ	est for Prede	terminatio	n/Preauthori	zation										
X EPSDT / Title >	XIX																	
2. Predetermination/F	Preauthoriza	ation N	lumber						Р	OLICYHOL	DER/S	UBSCRIB	ER INFORMA	TION (	(For Insuran	ce Company N	lamed in #3)	
									12	2. Policyholder	r/Subsc	riber Name (	Last, First, Middl	e Initial,	, Suffix), Add	dress, City, Sta	ite, Zip Code	
INSURANCE CO	MPANY/D	ENT	AL BE	NEFIT	PLAN INF	ORMAT	ION		┨.			NINI A						
3. Company/Plan Na	me, Address	s, City	, State,	Zip Cod	le					INGRAM, 1677 OLD			<b>1</b>					
Delta Dental	of RI									WINSTON			_					
P O Box 151	7									VVIIVSTON	N-SAL	_EIVI, INC	27 103					
Providence,	RI 02901	1-151	17						13	3. Date of Birth	n (MM/E	DD/CCYY)	14. Gender	15.	. Policyholde	er/Subscriber I	D (SSN or ID#)	
										07/15/197	79		M X	F 00	0022235	29		
OTHER COVERA	GE (Mark a	applica	able box	x and co	mplete items	5-11. If no	one, leave bl	ank.)	16	16. Plan/Group Number 17. Employer Name								
4. Dental?	Medical?			(If both,	complete 5-1	1 for denta	al only.)		1	7000-0001 CVS HEALTH								
5. Name of Policyholo	der/Subscrib	ber in	#4 (Las	st, First,	Middle Initial	Suffix)			P	ATIENT IN	FORM	ATION						
									18	3. Relationship	to Poli	icyholder/Sul	oscriber in #12 A	bove			ed For Future	
6. Date of Birth (MM/	DD/CCYY)	7	7. Gend	ler	8. Policyh	older/Sub	scriber ID (S	SN or ID#)	1	Self	Sp	oouse X	Dependent Chil	d 🔲	Other	Use		
			M	F				,	20	D. Name (Last,	, First, M	Middle Initial,	Suffix), Address	, City, St	tate, Zip Co	de		
9. Plan/Group Number 10. Patient's Relationship to Person named in #5								1	INGRAM,	FLLJ	АН							
Self Spouse Dependent Other									3566 THC			LE						
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code								_	WINSTON									
									21	21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (/							igned by Dentist)	
										11/27/200	00		X M	F  80	310616	2847		
RECORD OF SER	RVICES P	ROVI	IDED															
24. Procedure		. Area	26. Ta ette	2	7. Tooth Numb	er(s)	28. Tooth	29. Pro	cedure	29a. Diag.	29b.		20.1				24 5	
(MM/DD/CCY		f Oral Cavity	Tooth System		or Letter(s)		Surface	Co	de	Pointer	Qty.		30. 1	Descriptio	on		31. Fee	
1 11/28/2016								D867	0			PERIOD	ORTHO TX	INSTA	ALLMEN	Т	87.50	
2																		
3																		
4																		
5																		
6																		
7																		
8																		
9																		
10																		
33. Missing Teeth Info	rmation (Pl	ace ar	n "X" on	n each m	issing tooth.	)	3	34. Diagnosis	s Code	List Qualifier		( ICD-9 =	B; ICD-10 = AB	)		31a. Other		
1 2 3 4	5 6	7	8 9	9 10	11 12 1	3 14 1	5 16 3	34a. Diagnos	is Cod	e(s)	Α		c			Fee(s)		
32 31 30 29	28 27	26	25 2	4 23	22 21 2	0 19 1	8 17 (	Primary diag	gnosis	in " <b>A</b> ")	В		D			32. Total Fee	87.50	
35. Remarks																		
AUTHORIZATIO	NS								ANG	CILLARY CI	LAIM/	TREATME	NT INFORMA	TION				
36. I have been inform charges for dental									38. F	Place of Treatm	_		=office; 22=O/P H		39. Enclo	sures (Y or N)		
law, or the treating	dentist or d	lental p	practice	has a co	ontractual agr	eement wi	th my plan pr	ohibiting all		(Use "Place	of Service	ce Codes for P	rofessional Claims	")				
or a portion of suc of my protected he									40. Is	s Treatment fo					41. Date Ap	pliance Placed	(MM/DD/CCYY)	
X SIGNA	ATURE (	ON F	ILE			11	/28/2016			No (Ski	p 41-42	2) X Yes	(Complete 41-42	2)	11/3/201	4		
Patient/Guardian	Signature					Dat	е		42. N	Months of Trea	tment	43. Repla	cement of Prosth	esis 4	44. Date of	Prior Placemer	nt (MM/DD/CCYY)	
37. I hereby authorize					al benefits oth	erwise pa	yable to me,	directly	<u>L</u>	6		No	Yes (Complet	e 44)				
to the below name	ed dentist o	r dent	al entity	/.					45. T	reatment Res	ulting fr	om						
X SIGNA	ATURE (	ON F	FILE			11	/28/2016	i	Occupational illness/injury Auto accident Other accident						nt			
Subscriber Signature Date								46. Date of Accident (MM/DD/CCYY) 47. Auto Accident S							ent State			
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not							is not	TREATING DENTIST AND TREATMENT LOCATION INFORMATION										
submitting claim on behalf of the patient or insured/subscriber.)								53. I hereby certify that the procedures as indicated by date are in progress (for procedures that						es that require				
48. Name, Address, City, State, Zip Code								multiple visits) or have been completed.										
Kenneth M. Sadler, DDS and Associates, PA						lχ	Dr. Martir	n Slo	minski			1	1/28/2016					
201 Charlois Boulevard Winston-Salem, NC 27103						Signed (Treating Dentist) Date												
Williston-Galetti, NG 27 103							54. NPI 1790716421 55. License Number											
							56. Address, City, State, Zip Code Specialty Code 1223X0400X											
49. NPI		1		Number	r	51. SSN			201 Charlois Blvd									
1144309410		415	51			56-213	2966		Winston-Salem, NC 27103									
52. Phone Number (336) 331-3500   52a. Additional Provider ID									57. Phone Number (336) 331-3500   58. Additional Provider ID 903HC									

ADA American Dental Association® Dental Claim For	<u>m</u>				
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	POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)				
	12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code				
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	LITTLE, VICTOR				
3. Company/Plan Name, Address, City, State, Zip Code	2275 BRIAR GLENN RD				
DELTAL DENTAL OF MI PO BOX 9085	WINSTON-SALEM, NC 27127				
FARMINGTON HILLS, MI 48333	13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscriber ID (SSN or ID#)				
TATAMINATOR THEES, INIT HOUSE					
OTHER COVERAGE (Made and Sable has and assented flows 5 44 Manage leave black)	10/30/1971				
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)      Dental?    Medical?    (If both, complete 5-11 for dental only.)	0024-0001 VERTELLUS				
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)	PATIENT INFORMATION				
o. Name of Folloyfiolder/outsoriber in # 4 (Eds., Filst, Middle Initial, Odink)	18. Relationship to Policyholder/Subscriber in #12 Above 19. Reserved For Future				
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN or ID#)	Self   Spouse   X   Dependent Child   Other   Use				
M F	20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code				
9. Plan/Group Number 10. Patient's Relationship to Person named in #5	LITTLE, PEYTON A				
Self Spouse Dependent Other	2275 BRIAR GLENN RD				
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	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 25. Area 26. 27. Tooth Number(s) 28. Tooth 29. Proc					
(MM/DD/CCYY) Cavity System of Letter(s) Surface Cod	e Pointer Qty.				
1 11/28/2016 D8670	PERIOD ORTHO TX INSTALLMENT 199.58				
3					
4					
5					
6					
8					
9					
10					
	Code List Qualifier (ICD-9 = B; ICD-10 = AB) 31a. Other				
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 34a. Diagnosi	Fee(s)				
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 (Primary diag					
35. Remarks	7 5 5 100.00				
AUTHORIZATIONS	ANCILLARY CLAIM/TREATMENT INFORMATION				
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	38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) 39. Enclosures (Y or N)				
law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all	(Use "Place of Service Codes for Professional Claims")				
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.	40. Is Treatment for Orthodontics?  41. Date Appliance Placed (MM/DD/CCYY)				
X SIGNATURE ON FILE 11/28/2016	No (Skip 41-42) X Yes (Complete 41-42) 7/21/2016				
Patient/Guardian Signature Date	42. Months of Treatment 43. Replacement of Prosthesis 44. Date of Prior Placement (MM/DD/CCYY)				
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly	19 Yes (Complete 44)				
to the below named dentist or dental entity.	45. Treatment Resulting from				
X SIGNATURE ON FILE 11/28/2016	Occupational illness/injury Auto accident Other accident				
Subscriber Signature Date	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.)	TREATING DENTIST AND TREATMENT LOCATION INFORMATION				
49 Nama Address City State 7in Code	53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.				
48. Name, Address, City, State, Zip Code Kenneth M. Sadler, DDS and Associates, PA					
201 Charlois Boulevard	X_Dr Deborah F Novak 11/28/2016 Signed (Treating Dentist) Date				
Winston-Salem, NC 27103	Signed (Treating Dentist)         Date           54. NPI 1457441420         55. License Number				
	56. Address, City, State, Zip Code Sea. Provider Specialty Code 1223X0400X				
49. NPI 50. License Number 51. SSN or TIN	201 Charlois Blvd				
1144309410 4151 56-2132966	Winston-Salem, NC 27103				
52. Phone (236) 231 3500   52a. Additional	57. Phone Number (336) 331-3500   58. Additional Provider ID				
Number (330) 331-3300 Provider ID	Trumber 1 / Flovider ID				

ADA American Deni	tai Assoc	iation" <b>Dent</b>	ai Ciain	1 Forr	n								
HEADER INFORMATION													
Type of Transaction (Mark all apple)	icable boxes)				ı								
X Statement of Actual Services	Red	uest for Predetermination	on/Preauthoriza	tion									
X EPSDT / Title XIX					L								
2. Predetermination/Preauthorization	Number				P	OLICYHOL	DER/S	UBSCRIB	ER INFORM	MOITA	(For Insuran	nce Company N	lamed in #3)
					12	<ol><li>Policyholder</li></ol>	/Subsc	riber Name	(Last, First, Midd	dle Initial	l, Suffix), Ad	dress, City, Sta	ite, Zip Code
INSURANCE COMPANY/DEN	TAL BENEFI	T PLAN INFORMAT	TION		⅃.	FERNAND	)F7	SARA					
3. Company/Plan Name, Address, Ci	ity, State, Zip Co	ode				3116 GRE			SDR				
INTERACTIVE MEDICA	L SYSTEM	S				WINSTON							
PO BOX 1349					$\perp$								
WAKE FOREST, NC 27	588				13	13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscriber ID (							
					┸	03/21/197	76		M X	0	3566138	31	
OTHER COVERAGE (Mark appli	icable box and o	omplete items 5-11. If n	one, leave blan	k.)	16. Plan/Group Number 17. Employer Name								
4. Dental? Medical?	(If both	, complete 5-11 for dent	al only.)		3558								
5. Name of Policyholder/Subscriber i	n #4 (Last, First	, Middle Initial, Suffix)			PATIENT INFORMATION								
					18				bscriber in #12 /		7	19. Reserv Use	ed For Future
Date of Birth (MM/DD/CCYY)	7. Gender	8. Policyholder/Sub	scriber ID (SSN	l or ID#)	$\vdash$	X Self		oouse	Dependent Ch		Other		
	MF	elationship to Person na			20	0. Name (Last,	First, N	Middle Initial	, Suffix), Addres	s, City, S	State, Zip Co	ode	
9. Plan/Group Number			FERNAND	,									
	ther	4	WINSTON	I SAL	EM, NC	27107							
11. Other Insurance Company/Denta		1											
					21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assigned								:
						03/21/197		DD/CCYY)	22. Gender		3. Patient ID// 0509116	-	igned by Dentist)
					_	03/21/19/				]	0309110	2043	
RECORD OF SERVICES PRO	26		T	T		T I		I					
24. Procedure Date (MM/DD/CCYY) of Ora Cavity	l Tooth	<ol> <li>Tooth Number(s) or Letter(s)</li> </ol>	28. Tooth Surface	29. Proce Code		29a. Diag. Pointer	29b. Qty.		30.	Descripti	tion		31. Fee
1 11/28/2016	System			D8670				PERIOR	ORTHO T	( INST	TALL MEN	Т	356.67
2								1 EI GE	01(1110-17	(11401	T VELIVIEI V	•	000.07
3													
4													
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6													
7													
8													
9													
10													
33. Missing Teeth Information (Place	an "X" on each	missing tooth.)	34	Diagnosis (	Code	List Qualifier		(ICD-9 =	: B; ICD-10 = AB	:)		31a. Other	
1 2 3 4 5 6 7	8 9 10			. Diagnosis			<u></u>	(	C	,		Fee(s)	
32 31 30 29 28 27 26	25 24 23	22 21 20 19		imary diagn		:- «A»\	В					32. Total Fee	356.67
35. Remarks			,			· ·							000.01
AUTHORIZATIONS					ANC	CILLARY CI	AIM/	TREATME	NT INFORM	ATION			
36. I have been informed of the treatment					38. F	Place of Treatm	nent [	11 (e.g. 1	1=office; 22=O/P I	Hospital)	39. Enclo	sures (Y or N)	
charges for dental services and m law, or the treating dentist or denta	al practice has a	contractual agreement w	ith my plan proh	ibiting all		(Use "Place	of Service	ce Codes for F	Professional Claim	s")			
or a portion of such charges. To the of my protected health information					40. Is	s Treatment fo	r Ortho	dontics?			41. Date Ap	pliance Placed	(MM/DD/CCYY)
X SIGNATURE ON	FILE	11	/28/2016	L		No (Ski	p 41-42	Yes	(Complete 41-4	2)	2/8/2016	6	
Patient/Guardian Signature		Da	te		42. N	Months of Trea	tment	43. Repla	acement of Prost	hesis	44. Date of	Prior Placemen	nt (MM/DD/CCYY)
37. I hereby authorize and direct pay	ment of the den	tal benefits otherwise pa	yable to me, di	rectly		5		No [	Yes (Comple	ete 44)			
to the below named dentist or de		·			45. T	Freatment Res	ulting fr	om					
X SIGNATURE ON	FILE	11	/28/2016	L	Occupational illness/injury Auto accident Other accident						nt		
Subscriber Signature		46. Date of Accident (MM/DD/CCYY) 47. Auto Accident Stat							ent State				
BILLING DENTIST OR DENT	not	TREATING DENTIST AND TREATMENT LOCATION INFORMATION											
submitting claim on behalf of the pati		53. I hereby certify that the procedures as indicated by date are in progress (for procedures that re						es that require					
48. Name, Address, City, State, Zip Code						multiple visits) or have been completed.							
Kenneth M. Sadler, DDS and Associates, PA						Dr. Martin					1	1/28/2016	
201 Charlois Boulevard Winston-Salem, NC 27103						Signed (Treating Dentist) Date							
William Galetti, NO 27 100						54. NPI 1790716421 55. License Number							
						56. Address, City, State, Zip Code Specialty Code 1223X0400X							
l l	. License Numb				201 Charlois Blvd Winston-Salem, NC 27103								
F2 Phone	151	56-213 52a. Additional	2966		Winston-Salem, NC 27103								
52. Phone Number (336) 331-3500		52a. Additional Provider ID			57. Phone Number (336) 331-3500   58. Additional Provider ID 903HC								

ADA American Denta	ai Associa	ition" <b>Dent</b> a	ai Ciain	1 Forr	n								
HEADER INFORMATION													
Type of Transaction (Mark all applicable boxes)  X Statement of Actual Services Request for Predetermination/Preauthorization  X EPSDT / Title XIX													
I <u> </u>	Reque	est for Predetermination	n/Preauthorizat	tion									
					╄								
Predetermination/Preauthorization N	lumber				$\vdash$				ER INFORMA	<u>`</u>			
					<b>-</b> 112	2. Policyholder	/Subsc	riber Name (	Last, First, Midd	le Initial, S	Suffix), Add	lress, City, Sta	te, Zip Code
INSURANCE COMPANY/DENTA			ION		վ ւ	URIZAR, S	SARA	A					
<ol> <li>Company/Plan Name, Address, City,</li> <li>INTERACTIVE MEDICAL</li> </ol>		•			(	3116 GRE	ENE	CROSS	DR				
PO BOX 1349	SISIEWS				۱ ۱	WINSTON	I SAL	EM, NC	27107				
WAKE FOREST, NC 275	88				13	3. Date of Birth	(MM/E	DD/CCYY)	14. Gender	15. F	Policyholde	r/Subscriber II	D (SSN or ID#)
,						03/21/197	•	,	M X	- 1	566138		(00.10.10.17)
OTHER COVERAGE (Mark applica	able box and com	nnlete items 5-11. If no	one leave blan	k )	-	6. Plan/Group I		r 1	17. Employer Na		300 130		
4. Dental? Medical?		omplete 5-11 for denta		i.,	-	3558			GUILFORD		ITY		
5. Name of Policyholder/Subscriber in	•				P	ATIENT INF	ORM	ATION					
·	, , ,	, ,			18. Relationship to Policyholder/Subscriber in #12 Above 19. Reserved Fo							ed For Future	
6. Date of Birth (MM/DD/CCYY) 7	7. Gender	8. Policyholder/Subs	scriber ID (SSN	l or ID#)	Self Spouse X Dependent Child Other								
	M F		,	,	20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
9. Plan/Group Number 1	10. Patient's Rela	ationship to Person na	med in #5		URIZAR-ARIAS, JOSHABET								
	Self	Spouse Depe	ndent O	ther	3116 GREENE CROSS DR								
11. Other Insurance Company/Dental E	Benefit Plan Nam	ne, Address, City, State	e, Zip Code		7	WINSTON	I SAL	EM, NC	27107				
					L								
						1. Date of Birth	•	DD/CCYY)	22. Gender	- 1			gned by Dentist)
						10/10/200	)3		M X	F   805	5061162	2844	
RECORD OF SERVICES PROVIDED													
24. Procedure Date (MM/DD/CCYY) 25. Area of Oral Tooth or Letter(s) 28. Tooth 29. Procedure Control of Letter(s) Surface C						re 29a. Diag. 29b. 30. Description Qty.							31. Fee
1 11/28/2016 Cavity	System	or Editor(b)	- Curius	D8670		1 onto		DEDIOD	ORTHO TX	INICTA	LIMENI	т	125.00
2				D6070				PERIOD	OKINO IX	INSTA	LLIVIEIN	ı	125.00
3													
4													
5													
6													
7													
8													
9													
10													
33. Missing Teeth Information (Place ar	n "X" on each mis	ssing tooth.)	34.	Diagnosis (	Code	List Qualifier		( ICD-9 =	B; ICD-10 = AB	)		31a. Other	
1 2 3 4 5 6 7	8 9 10	11 12 13 14 1	5 16 34a	. Diagnosis	Code	le(s)	Α		c			Fee(s)	
32 31 30 29 28 27 26	25 24 23 2	22 21 20 19 18	8 17 (Pri	mary diagr	osis i	in " <b>A</b> ")	В		D			32. Total Fee	125.00
35. Remarks													
AUTHORIZATIONS									NT INFORMA		00 5 1	0/ - 10	
36. I have been informed of the treatme charges for dental services and mat	terials not paid by	my dental benefit plar	n, unless prohib	ited by	38. P	Place of Treatm			=office; 22=O/P H rofessional Claims		39. Enclos	sures (Y or N)	
law, or the treating dentist or dental parties or a portion of such charges. To the				locuro E	40 1-	s Treatment for			Tolessional olaims		1 Deta Ani	Liones Diseas	(MM/DD/CC)VV
of my protected health information to				aim.	40. IS	No (Ski			(Complete 41-42				(MM/DD/CCYY)
X SIGNATURE ON F Patient/Guardian Signature	-ILE	11/ 	/28/2016 e	— ŀ	42 M	Months of Treat			cement of Prostr	<del></del>	10/2/201 4 Date of F		t (MM/DD/CCYY)
					- <b>τ∠.</b> IV	24	ancill	No No	Yes (Complet		T. Date UI	nor maderner	(1110010011)
<ol> <li>I hereby authorize and direct payme to the below named dentist or dental</li> </ol>		benefits otherwise pay	yable to me, dii		45. T	Σ <del>1</del> Γreatment Resi	ultina fr			,			
	•	11	/28/2016				-	ness/injury	Auto	accident		Other accider	nt
X SIGNATURE ON F Subscriber Signature	ILE	Date		—	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				_	TREATING DENTIST AND TREATMENT LOCATION INFORMATION								
submitting claim on behalf of the patient or insured/subscriber.)					TREATING DENTIST AND TREATMENT LOCATION INFORMATION  53. I hereby certify that the procedures as indicated by date are in progress (for procedures that re					es that require			
48. Name, Address, City, State, Zip Code					53. I nereby certify that the procedures as indicated by date are in progress (for procedures that remultiple visits) or have been completed.					·			
Kenneth M. Sadler, DDS and	Associates, F	PA			X	Dr. Martin	Slo	minski			11	/28/2016	
201 Charlois Boulevard Winston-Salem, NC 27103					X         Dr. Martin Slominski         11/28/2016           Signed (Treating Dentist)         Date								
willston-salem, NC 2/103				Ī	54. N	NPI 17907	1642	21		5. License			
					56. A	Address, City, S	State, Z	ip Code	5/ S	6a. Provid pecialty C	ler ode 122	23X0400X	
l I	_icense Number	51. SSN				Charlois Blvo		102	_				
1144309410 415		56-213	2966			ston-Salem, I			1.5	O A -1 -1'-1'			
<sup>52. Phone</sup> Number (336) 331-3500		52a Additional Provider ID			57. Phone Number (336) 331-3500   58. Additional Provider ID 903HC								

ADA American Dental Association® Dental Claim Form	<u>n</u>								
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	POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)								
	12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	NIXON, HOPE								
Company/Plan Name, Address, City, State, Zip Code     MEDCOST	3740 WESTWOOD RD								
PO BOX 25987	HAMPTONVILLE, NC 27020								
WINSTON-SALEM, NC 27114	13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscriber ID (SSN or ID#)								
·	06/11/1976								
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)	16. Plan/Group Number 17. Employer Name								
4. Dental? Medical? (If both, complete 5-11 for dental only.)	3365 WFUBMC								
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)	PATIENT INFORMATION								
	18. Relationship to Policyholder/Subscriber in #12 Above 19. Reserved For Future								
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN or ID#)	Self Spouse X Dependent Child Other								
	20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
9. Plan/Group Number 10. Patient's Relationship to Person named in #5	NIXON, LUCAS								
Self Spouse Dependent Other	3740 WESTWOOD RD								
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	HAMPTONVILLE, NC 27020								
	24 Date of Pitth (MM/DD/CCVV) 22 Conder 22 Patient ID/Associat # (Assigned by Dantiet								
	21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assigned by Dentist 802185162843								
RECORD OF SERVICES PROVIDED	07700/2000								
24 Procedure Date 25. Area 26. 27 Tooth Number(s) 28 Tooth 29 Procedure	dure 29a Diag. 29b.								
(MM/DD/CCYY) Cavity   Tooth   Cavity   System   Cavity									
1 11/28/2016 D8670	PERIOD ORTHO TX INSTALLMENT 199.5								
2									
3									
4									
5									
6									
7									
8									
9									
33. Missing Teeth Information (Place an "X" on each missing tooth.) 34. Diagnosis C	Code List Qualifier (ICD-9 = B; ICD-10 = AB ) 31a. Other								
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 34a. Diagnosis	Fee(s)								
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 (Primary diagn									
35. Remarks	5								
	ANCILLARY CLAIM/TREATMENT INFORMATION								
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	38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) 39. Enclosures (Y or N)								
law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all	(Use "Place of Service Codes for Professional Claims")								
of my protected health information to carry out payment activities in connection with this claim.	40. Is Treatment for Orthodontics?  41. Date Appliance Placed (MM/DD/CCYY  No (Skip 41-42) X Yes (Complete 41-42)  9/15/2015								
X SIGNATURE ON FILE 11/28/2016 Patient/Guardian Signature Date	No (Skip 41-42) X Yes (Complete 41-42) 9/15/2015  42. Months of Treatment 43. Replacement of Prosthesis 44. Date of Prior Placement (MM/DD/CCY)								
	43. Replacement of Prostnesis 44. Date of Prior Placement (initivi)DD/CCY1								
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.	45. Treatment Resulting from								
44/00/0040	Occupational illness/injury Auto accident Other accident								
N   N	46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State								
	TREATING DENTIST AND TREATMENT LOCATION INFORMATION								
submitting claim on behalf of the patient or insured/subscriber.)	53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require								
48. Name, Address, City, State, Zip Code	multiple visits) or have been completed.								
Kenneth M. Sadler, DDS and Associates, PA	χ Dr Deborah F Novak 11/28/2016								
201 Charlois Boulevard Winston-Salem, NC 27103	Signed (Treating Dentist)  Date								
	54. NPI 1457441420 55. License Number								
	56. Address, City, State, Zip Code Sec. Provider Specialty Code 1223X0400X								
	201 Charlois Blvd Winston-Salem, NC 27103								
52. Phone (236) 234, 2500   52a. Additional	57. Phone (226) 224 2500   58. Additional								
Number (336) 331-3300 Provider ID	Number (336) 331-3500 Provider ID								

ADA American Dental Association D	entai Ciaim	Form									
HEADER INFORMATION											
Type of Transaction (Mark all applicable boxes)											
X Statement of Actual Services Request for Predetern	mination/Preauthorizatio	n									
X EPSDT / Title XIX		L									
2. Predetermination/Preauthorization Number		- 1	POLICYHOLI	DER/S	UBSCRIB	ER INFORMATI	ON (For Insura	nce Company N	lamed in #3)		
		1	12. Policyholder	/Subsc	riber Name (	Last, First, Middle I	nitial, Suffix), Ad	ddress, City, Sta	ite, Zip Code		
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFO	RMATION		BROWN,	IACC	JUELINE						
3. Company/Plan Name, Address, City, State, Zip Code						RD APT C39					
MEDCOST BENEFIT SERVICES			WINSTON								
PO BOX 25987			WINSTON		LLIVI, INC	27 103					
WINSTON SALEM, NC 27114		1	13. Date of Birth	(MM/E	DD/CCYY)	14. Gender	15. Policyhold	der/Subscriber I	D (SSN or ID#)		
			03/07/199	91		M X F	A013172	0700			
OTHER COVERAGE (Mark applicable box and complete items 5-	11. If none, leave blank.)	) 1	16. Plan/Group I	Numbe	er 1	7. Employer Name	)				
4. Dental? Medical? (If both, complete 5-11 for	or dental only.)		3372		\	VFUBMC					
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Su	ffix)	1	PATIENT INFORMATION								
		1	18. Relationship to Policyholder/Subscriber in #12 Above 19. Reserved For								
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyhold	er/Subscriber ID (SSN o	or ID#)	X Self Spouse Dependent Child Other								
		2	20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
Plan/Group Number	son named in #5		BROWN, JACQUELINE S								
Self Spouse	Dependent Othe	er	APT C39								
11. Other Insurance Company/Dental Benefit Plan Name, Address, Cit	y, State, Zip Code		WINSTON	I SAL	EM, NC	27103					
	2	21. Date of Birth	(MM/E	DD/CCYY)	22. Gender	23. Patient ID	/Account # (Ass	igned by Dentist)			
		03/07/199	91		M X F	80502916	52842				
RECORD OF SERVICES PROVIDED											
24. Procedure Date 25. Area 26. 27. Tooth Number(s	) 28. Tooth	29. Procedure	re 29a, Diag. 29b.						24 5		
(MM/DD/CCYY) of Oral Tooth Cavity System or Letter(s)	Surface	Code	Pointer Qty. 30. Description						31. Fee		
1 11/28/2016		D8670			PERIOD	ORTHO TX II	NSTALLMEN	NT	297.22		
2											
3											
4											
5											
6											
7											
8											
9											
10											
33. Missing Teeth Information (Place an "X" on each missing tooth.)	34. Di	iagnosis Code	le List Qualifier		( ICD-9 =	B; ICD-10 = AB )		31a. Other			
1 2 3 4 5 6 7 8 9 10 11 12 13	14 15 16 34a. [	Diagnosis Co	ode(s)	A		c		Fee(s)			
32 31 30 29 28 27 26 25 24 23 22 21 20	19 18 17 (Prim	ary diagnosis	s in " <b>A</b> ")	В		D		32. Total Fee	297.22		
35. Remarks											
AUTHORIZATIONS		AN	ICILLARY CL	AIM/	TREATME	NT INFORMAT	ION				
36. I have been informed of the treatment plan and associated fees. I ag			Place of Treatm	ent	11 (e.g. 11	=office; 22=O/P Hosp	oital) 39. Encl	osures (Y or N)			
charges for dental services and materials not paid by my dental ben- law, or the treating dentist or dental practice has a contractual agreer			(Use "Place of	of Servi	ce Codes for P	rofessional Claims")					
or a portion of such charges. To the extent permitted by law, I conset of my protected health information to carry out payment activities in			Is Treatment for	r Ortho	dontics?		41. Date A	ppliance Placed	(MM/DD/CCYY)		
X SIGNATURE ON FILE	11/28/2016	"	No (Skip	p 41-42	2) X Yes	(Complete 41-42)	8/10/20	15			
Patient/Guardian Signature	Date	42.	Months of Treat	tment	43. Repla	cement of Prosthes	is 44. Date of	f Prior Placemer	nt (MM/DD/CCYY)		
37. I hereby authorize and direct payment of the dental benefits otherw	isa navahla ta ma dirar	othy	2		No	Yes (Complete	14)				
to the below named dentist or dental entity.	rise payable to file, direc		Treatment Resu	ulting fr	om						
X SIGNATURE ON FILE	11/28/2016		Occupat	ional ill	ness/injury	Auto ac	cident	Other accide	nt		
X SIGNATURE ON FILE Subscriber Signature	Date	46.	46. Date of Accident (MM/DD/CCYY) 47. Auto Accident Sta						ent State		
BILLING DENTIST OR DENTAL ENTITY (Leave blank if den	t TR	TREATING DENTIST AND TREATMENT LOCATION INFORMATION									
submitting claim on behalf of the patient or insured/subscriber.)		TREATING DENTIST AND TREATMENT LOCATION INFORMATION  53. I hereby certify that the procedures as indicated by date are in progress (for procedures that re-						es that require			
48. Name, Address, City, State, Zip Code		53. I hereby certify that the procedures as indicated by date are in progress (for procedures that remultiple visits) or have been completed.									
Kenneth M. Sadler, DDS and Associates, PA											
201 Charlois Boulevard		X	<b></b>				1	1/28/2016 Date			
Winston-Salem, NC 27103		54.	Signed (Treating Dentist)   Date								
			Address, City, S				Provider cialty Code 12				
49. NPI 50. License Number 51	. SSN or TIN		1 Charlois Blvd			Spe	cialty Code 12	. <u>~</u> J/\U4\U/\	•		
	5-2132966		nston-Salem, I		103						
52. Phone (236) 234 3500   52a. Additional		57.	Phone (33	6) 33	1-3500	58.7	Additional 90	13HC			
Number (336) 331-3300 Provider II	J		Number (33	2, 30	. 5555		-roviaer ID 30	.5.10			

ADA American Dentai /	Association Denta	ai Ciaim	Form									
HEADER INFORMATION												
Type of Transaction (Mark all applicable	Type of Transaction (Mark all applicable boxes)  X Statement of Actual Services Request for Predetermination/Preauthorization  X EPSDT / Title XIX											
X Statement of Actual Services	Request for Predetermination	n/Preauthorizatior	ո									
X EPSDT / Title XIX												
2. Predetermination/Preauthorization Num	mber		F	POLICYHOLI	DER/S	UBSCRIB	ER INFORMAT	ION (For Insur	ance Company N	lamed in #3)		
			1	12. Policyholder	/Subsc	riber Name (	Last, First, Middle	Initial, Suffix), A	ddress, City, Sta	ite, Zip Code		
INSURANCE COMPANY/DENTAL	BENEFIT PLAN INFORMAT	ION			A I I	CTACV	Ь					
3. Company/Plan Name, Address, City, Sta	tate, Zip Code			HARPE-H.	,							
MEDCOST BENEFIT SERV	VICES			LEXINGT(								
PO BOX 25987				LEXINGIC	JIN, I	NC 2729	,					
WINSTON SALEM, NC 271	114		1	13. Date of Birth	(MM/E	DD/CCYY)	14. Gender	15. Policyho	Ider/Subscriber I	D (SSN or ID#)		
				04/04/197	'4		M X F	A000402	29200			
OTHER COVERAGE (Mark applicable	e box and complete items 5-11. If no	one, leave blank.)	1	16. Plan/Group I	Numbe	er 1	17. Employer Nam	ie				
4. Dental? Medical?	(If both, complete 5-11 for denta	al only.)		3372		\	NFUBMC					
5. Name of Policyholder/Subscriber in #4	(Last, First, Middle Initial, Suffix)		F	PATIENT INFORMATION								
			1	18. Relationship to Policyholder/Subscriber in #12 Above 19. Reserved For								
6. Date of Birth (MM/DD/CCYY) 7. G	Gender 8. Policyholder/Subs	scriber ID (SSN or	· ID#)	Self Spouse X Dependent Child Other								
_			2	20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
9. Plan/Group Number 10. I	Patient's Relationship to Person na	med in #5		HARPE, NATALIE G								
	Self Spouse Depe	ndent Othe	r	1212 HOR		_	CK ROAD					
11. Other Insurance Company/Dental Ben	nefit Plan Name, Address, City, State	e, Zip Code		LEXINGTO								
	2	21. Date of Birth	(MM/E	DD/CCYY)	22. Gender	23. Patient II	D/Account # (Ass	igned by Dentist)				
		03/20/200	3		M X F	8050601	62841					
RECORD OF SERVICES PROVIDE												
	26. 27. Tooth Number(s)	28. Tooth	29. Procedure	e 29a. Diag.	29b.		20.5			04.5		
(MM/DD/CCVV) of Oral Too	ooth or Letter(s)	Surface	Code	Pointer Qty. 30. Description						31. Fee		
1 11/28/2016			08670			PERIOD	ORTHO TX I	NSTALLME	NT	206.25		
2												
3												
4												
5												
6												
7												
8												
9												
10												
33. Missing Teeth Information (Place an "X	X" on each missing tooth.)	34. Dia	agnosis Code	e List Qualifier		( ICD-9 =	B; ICD-10 = AB )		31a. Other			
1 2 3 4 5 6 7 8	9 10 11 12 13 14 15	5 16 34a. D	iagnosis Cod	de(s)	A		c		Fee(s)			
32 31 30 29 28 27 26 25	5 24 23 22 21 20 19 1	8 17 (Prima	ary diagnosis	s in " <b>A</b> ")	В		D		32. Total Fee	206.25		
35. Remarks												
AUTHORIZATIONS			AN	ICILLARY CL	AIM/	TREATME	NT INFORMAT	ION				
36. I have been informed of the treatment p				Place of Treatm	ent	11 (e.g. 11	=office; 22=O/P Hos	spital) 39. End	closures (Y or N)			
charges for dental services and materia law, or the treating dentist or dental practice.	actice has a contractual agreement wil	th my plan prohibit	ing all	(Use "Place of	of Service	ce Codes for P	rofessional Claims")					
or a portion of such charges. To the extended of my protected health information to care				Is Treatment for	r Ortho	dontics?		41. Date	Appliance Placed	(MM/DD/CCYY)		
X SIGNATURE ON FIL		/28/2016		No (Skip	41-42	2) X Yes	(Complete 41-42)	10/7/20	015			
Patient/Guardian Signature	Date	е	42.	Months of Treat	tment	43. Repla	cement of Prosthe	sis 44. Date	of Prior Placemer	nt (MM/DD/CCYY)		
37. I hereby authorize and direct payment	t of the dental benefits otherwise pay	vable to me. direc	tlv	10		No	Yes (Complete	44)				
to the below named dentist or dental e		, 4.2.0 10 11.0, 4.1.00		Treatment Resu	ulting fr	rom						
X SIGNATURE ON FIL	IF 11/	/28/2016		Occupat	ional ill	Iness/injury	Auto a	ccident	Other accide	nt		
Subscriber Signature	Date		46.	46. Date of Accident (MM/DD/CCYY) 47. Auto Acciden					ent State			
BILLING DENTIST OR DENTAL E	TRI	TREATING DENTIST AND TREATMENT LOCATION INFORMATION										
submitting claim on behalf of the patient or	53.	53. I hereby certify that the procedures as indicated by date are in progress (for procedures that re						es that require				
48. Name, Address, City, State, Zip Code		multiple visits) or have been completed.										
Kenneth M. Sadler, DDS and Ass	ssociates, PA		l <sub>v</sub>	Dr. Martin	Slo	minski			11/28/2016			
201 Charlois Boulevard			^-						Date			
Winston-Salem, NC 27103			54.	Signed (Treating Dentist)         Date           54. NPI 1790716421         55. License Number								
				Address, City, S			56a	a. Provider ecialty Code 1	223X0400X	,		
49. NPI 50. Lice	ense Number 51. SSN o	or TIN		1 Charlois Blvo			[ 35	, 0040				
1144309410 4151	56-213	2966	Win	nston-Salem, N	NC 27	103						
52. Phone Number (336) 331-3500	52a. Additional Provider ID		57.	Phone Number (33	6) 33	1-3500	58.	Additional 9 Provider ID	03HC			
	I TOYIGET ID							ID				

_	ADA American De	ental	Ass	ociation	Dent	al Cla	aim Fo	rm								
- 1	HEADER INFORMATION							_								
	. Type of Transaction (Mark all															
	X Statement of Actual Servi	ices		Request for Predet	erminatio	n/Preautho	orization									
L	X EPSDT / Title XIX															
	Predetermination/Preauthoriz	ation Nu	ımber					- ⊢				ER INFORMA		•		
⊢								$ 1^{1}$	12. Policyholder	/Subsc	riber Name (	(Last, First, Midd	le Initia	il, Suffix), Add	ress, City, Sta	te, Zip Code
- 1-	NSURANCE COMPANY/I				ORMAT	ION		_	KIRK, RE	GINA	١					
l <sup>3</sup>	6. Company/Plan Name, Addres			•					6430 ROE	BINH	OOD TRA	ACE RD				
Т	MEDCOST BENEFIT PO BOX 25987	I SEK	VICES	5					WINSTON	I SAI	_EM, NC	27106				
	WINSTON SALEM. I	NC 27	114					-	13. Date of Birth	\/\A\\\/\	DI/CCVV)	14. Gender	15	E Daliaubalda	r/Cubcaribar II	D (SSN or ID#)
	Will to Fort Of the Line, I							- [	04/05/197	•	DD/CCTT)	M X	- 1	,		D (33N 01 1D#)
ŀ	THER COVERAGE (Mart		la hav a		F 44 15	!	hlank)	-	04/05/197 16. Plan/Group		r .	17. Employer Na		0003036	500	
-	DTHER COVERAGE (Mark Dental? X Medical?			both, complete 5-1			DIATIK.)	ऻॱ	3372	Numbe		17. Employer Na	iiie			
$\vdash$	i. Name of Policyholder/Subscri					ai Oiliy.)		٠,	PATIENT IN	- OPM	ATION					
٦	KENNETH L KIRK	ibei iii #	4 (Last, I	Tirst, Middle IIIIdai,	Ouilix)			F				bscriber in #12 A	hovo		19 Reserv	ed For Future
g	Date of Birth (MM/DD/CCYY)	7	Gender	. Policyh	oldor/Sub	soribor ID	(SSN or ID#)	⊢ '	Self		· —	Dependent Chi		Other	Use	ou i oi i utaio
٦	09/02/1969		M [	7 F 230271		Scriber ID	(3314 01 10#)					, Suffix), Address			 le	
9	. Plan/Group Number			t's Relationship to F		med in #5		┨`	•			, oum,,,, , , , , , , , , , , , , , , , , ,	,, 0.0,, 0	otato, E.p oot		
ľ	5995847		Self		X Depe	_	Other		KIRK, KIE 6430 ROE			ACF RD				
1	Other Insurance Company/D	ental Be	enefit Pla				 e	$\dashv$	WINSTON			_				
	METLIFE										•					
	PO BOX 981282							2	21. Date of Birth	n (MM/[	DD/CCYY)	22. Gender	23	3. Patient ID/A	ccount # (Assi	igned by Dentist)
1	EL PASO, TX 79998	3							05/14/200	)2		M X	F 8	05073162	2840	
1	RECORD OF SERVICES PROVIDED										•					
┢	24. Procedure Date		26.	27. Tooth Numbe	r(s)	28. Too		cedure		29b.		30	Descript	tion		31. Fee
L	(MM/DD/CCYY) Or Cavity System or Letter(s) Surface					e Co	de	Pointer	Qty.		30.	Descript			31.1 66	
						D867	0			PERIOD	ORTHO TX	INST	TALLMENT	Γ	250.00	
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9																
1			#3.4P				101.01		1110 115					1,	4 - 011	
F	3. Missing Teeth Information (P		"X" on ea	ach missing tooth.)	14 1	5 16	_ <u> </u>		e List Qualifier		( ICD-9 =	B; ICD-10 = AB	)		1a. Other Fee(s)	
⊢	32 31 30 29 28 27					8 17	34a. Diagno (Primary dia		. ,	A		c		——  -	2. Total Fee	050.00
B 3	5. Remarks	20 2	.5 24	25 22 21 20	19 1	17	(i filliary dia	igriosis	5 III A )	В		D			2. Total 1 00	250.00
-   `	o. Remarko															
1	UTHORIZATIONS							TAN	ICILLARY CI	LAIM/	TREATME	NT INFORMA	TION	1		
3	6. I have been informed of the t							+-	Place of Treatm			1=office; 22=O/P H			ures (Y or N)	
	charges for dental services a law, or the treating dentist or							1	(Use "Place	of Servi	ce Codes for F	Professional Claims	5")			
	or a portion of such charges. of my protected health inform							40.	Is Treatment fo	r Ortho	dontics?			41. Date App	oliance Placed	(MM/DD/CCYY)
Ь			•	ic payment dearnage		/28/201		1	No (Ski	p 41-42	2) X Yes	(Complete 41-42	2)	12/9/201	5	
ľ	Patient/Guardian Signature				Dat	te		42.	Months of Trea	tment	43. Repla	cement of Prosth	nesis	44. Date of F	rior Placemen	it (MM/DD/CCYY)
3	7. I hereby authorize and direc	t pavmer	nt of the	dental benefits other	erwise pa	vable to m	e, directly	1	7		No [	Yes (Comple	te 44)			
	to the below named dentist of						,	45.	Treatment Res	ulting fr	rom					
Ь	X SIGNATURE ON FILE 11/28/2016					16	Occupational illness/injury Auto accident Other accident						nt			
L	Subscriber Signature Date						46. Date of Accident (MM/DD/CCYY) 47. Auto Accident St						ent State			
	BILLING DENTIST OR DE				entist or	dental entit	ty is not	TR	EATING DEI	NTIST	AND TRE	EATMENT LO	CATIO	ON INFORM	MATION	
⊢				ed/subscriber.)					I hereby certify multiple visits)			s as indicated by	date ar	re in progress	(for procedure	es that require
- 1	8. Name, Address, City, State,	-		DA				1	maniple viole)	or marc	, poon compi	iotou.				
	Kenneth M. Sadler, DDS 201 Charlois Boulevard	and A	ssocia	ites, PA				X	Dr. Martin					11	/28/2016	
	Winston-Salem, NC 2710	03						54	Signed (Trea			5	5 Licor	nse Number	Date	
								_	NPI 17907 Address, City, 8						2704007	
	9. NPI	50 11	cense Nu	umber	51. SSN	or TIN		-1	Charlois Blv			<u>[S</u>	pecialty	y Code 122	3X0400X	
	1144309410	4151			51. SSN 56-213				nston-Salem, l		103					
	2. Phone (226) 224 250			52a. Addition	nal			57.	Phone (33	36) 33	1-3500	5	8. Addit	tional rider ID 903	HC	
- 1	Number (336) 331-330	-		Provide	ו וט				Number (33	-, -			riov	Tuel ID 550		

	<b>DA</b> American L	Jeni	al As	SOCI	ation	Dent	ai Ciai	m For	m								
-	EADER INFORMATION																
1.	Type of Transaction (Mark a	all applic	able bo	xes)													
	X Statement of Actual Ser	rvices		Requ	est for Prede	terminatio	n/Preauthoriz	zation									
L	X EPSDT / Title XIX								ᆜ								
2.	Predetermination/Preauthor	rization	Number	,					_							ce Company N	
L									12	2. Policyholde	r/Subsc	riber Name (	Last, First, Mid	dle Ini	tial, Suffix), Ad	dress, City, Sta	ite, Zip Code
-	SURANCE COMPANY					ORMAT	ION		╡.	TURNER,	AQL	JILLA					
3.	Company/Plan Name, Addr MEDCOST BENEF	-		•	ie				-	152 BRO	OKHI	LL PARK	CT				
l	PO BOX 25987	11 25	RVIC	ES					1	RURAL H	ALL,	NC 2704	5-9634				
l	WINSTON SALEM.	NC 2	27114						13	B. Date of Birtl	h (MM/F	DD/CCYY)	14. Gender		15 Policyhold	er/Subscriber I	D (SSN or ID#)
l										04/20/198	,	,	M X	- 1	A0009607		- (,
ļ-	THER COVERAGE (Mar	rk applic	able bo	x and co	mplete items	5-11. If no	one, leave bla	ank.)	_	6. Plan/Group		er 1	7. Employer N		710000007	10	
-	Dental? Medica	<del></del>			complete 5-1					3372		\	NFBMC				
5.	Name of Policyholder/Subs	criber in	#4 (La	st, First,	Middle Initial,	Suffix)			P	ATIENT IN	FORM	ATION					
l									10. I telationiship to 1 olioyholden edbooriber iii // 12/tbove							ed For Future	
6.	Date of Birth (MM/DD/CCY)	Y)	7. Geno	der	8. Policyh	older/Sub	scriber ID (S	SN or ID#)	Self Spouse X Dependent Child Other								
L			М	F					20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
9.	Plan/Group Number				lationship to				NELSON, AMYA								
L			Se		Spouse	ш.		Other	_	152 BRO							
11	Other Insurance Company	/Dental	Benefit	Plan Na	me, Address,	City, State	e, Zip Code			RURAL H	ALL,	NC 2704	5-9634				
							21	. Date of Birtl	h (MM/F	DD/CCVV)	22. Gender		23 Patient ID/	Account # (Ass	igned by Dentist)		
								01/19/200		00/0011)	M X	_	80513316	-	ighted by Dentist)		
RECORD OF SERVICES PROVIDED																	
24 Procedure Date 25. Area 26. 27 Tooth Number(s) 28 Tooth 29 Pr						29. Prod	edure	re 29a, Diag. 29b. 30 Dougleton									
L	(MM/DD/CCYY)	of Oral Cavity			or Letter(s)	(-)	Surface	Cod		Pointer Qty. 30. Description							31. Fee
1	11/28/2016							D8670	)			PERIOD	ORTHO T	X INS	STALLMEN	Т	199.58
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33	Missing Teeth Information	(Place a	n "X" or	n each m	nissing tooth.)	)	3	4. Diagnosis	Code	List Qualifier		( ICD-9 =	B; ICD-10 = AE	3)		31a. Other	
Г	1 2 3 4 5 6	6 7	8 !	9 10	11 12 1	3 14 1		4a. Diagnos			Α		C			Fee(s)	
Г	32 31 30 29 28 2	7 26	25 2	4 23	22 21 2	0 19 1	8 17 (	Primary diag	nosis	in " <b>A</b> ")	в		D			32. Total Fee	199.58
35	. Remarks																
L																	
-	JTHORIZATIONS				:	1 4-	h	I II	⊢				NT INFORM			O/ ND	
36	I have been informed of the charges for dental services	and ma	iterials r	ot paid b	y my dental b	enefit plai	n, unless prof	nibited by	38. P		_		=office; 22=O/P rofessional Clain		al) 39. Encic	sures (Y or N)	
l	law, or the treating dentist of or a portion of such charge.	s. To the	extent	permitte	d by law, I cor	nsent to yo	ur use and di	isclosure	40 16	Treatment fo			Toronoman orani	,	11 Date Ar	nliance Placed	I (MM/DD/CCYY)
L	of my protected health info			out payr	nent activities		tion with this /28/2016	claim.	-0.1	No (Ski			(Complete 41-4	12)	8/3/2016		(MINI/DD/0011)
١×	SIGNATURE Patient/Guardian Signature		FILE			Dat			42. N	Nonths of Trea			cement of Pros				nt (MM/DD/CCYY)
27	. I hereby authorize and dire		oont of t	ho donto	l honofite oth	onviso na	vable to me	diroctly	l	20		No [	Yes (Compl				,
"	to the below named dentis				ii bellellis oti	iei wise pa	yable to me,	directly	45. Treatment Resulting from								
$ _{x}$	SIGNATURE	ON	FILE			11	/28/2016		Occupational illness/injury Auto accident Other accident						nt		
Ĺ	X SIGNATURE ON FILE 11/28/2016 Subscriber Signature Date						46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State						ent State				
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not					s not	TREATING DENTIST AND TREATMENT LOCATION INFORMATION											
submitting claim on behalf of the patient or insured/subscriber.)						53. I hereby certify that the procedures as indicated by date are in progress (for procedures that requir multiple visits) or have been completed.						es that require					
	Name, Address, City, State				DA				Ι "	iaiupie visits)	or nave	, seem compr	O.Ou.				
	Kenneth M. Sadler, DDS and Associates, PA 201 Charlois Boulevard						X Dr Deborah F Novak 11/28/2016										
	inston-Salem, NC 27								Signed (Treating Dentist)         Date           54. NPI         1457441420         55. License Number								
									_							22704007	
49	. NPI	50	License	Numbe	r	51. SSN	or TIN		56. Address, City, State, Zip Code Specialty Code 1223X0400X  201 Charlois Blvd								
	44309410	41		, , anibe		56-213						103					
52	Phone Number (336) 331-35	 500			52a. Additio Provide	nal			Winston-Salem, NC 27103  57. Phone Number (336) 331-3500   58. Additional Provider ID								

ADA American L	ent	ai As	SOCI	ation° i	Denta	ai Ciai	m For	m								
HEADER INFORMATION	1															
Type of Transaction (Mark a	Type of Transaction (Mark all applicable boxes)  X Statement of Actual Services Request for Predetermination/Preauthorization  EPSDT / Title XIX															
X Statement of Actual Se	rvices		Requ	est for Predet	erminatior	n/Preauthoriz	zation									
X EPSDT / Title XIX																
2. Predetermination/Preauthor	ization l	Number						Р	OLICYHOL	DER/S	UBSCRIB	ER INFORMA	TION (F	For Insuran	ce Company N	lamed in #3)
								12	2. Policyholder	r/Subsc	riber Name (	Last, First, Middle	e Initial,	Suffix), Add	lress, City, Sta	ite, Zip Code
INSURANCE COMPANY	/DENT	AL BE	NEFIT	PLAN INF	ORMAT	ION		╗,		^ DI						
3. Company/Plan Name, Addr	ess, Cit	y, State,	Zip Cod	le				- 1	UPADHYA	,						
MEDCOST BENEF	IT SE	RVIC	ES					- 1	142 COVI LEWISVIL	_	_					
PO BOX 25987									LEVVISVIL	-L⊏, I	NC 2702.	3				
WINSTON SALEM	, NC 2	27114						13	3. Date of Birth	n (MM/E	DD/CCYY)	14. Gender	15.	Policyholde	er/Subscriber I	D (SSN or ID#)
									01/31/197	71		M X	F A0	008622	700	
OTHER COVERAGE (Mai	k applic	able bo	x and co	mplete items	5-11. If no	ne, leave bl	ank.)	16	6. Plan/Group	Numbe	er '	17. Employer Nar	me			
4. Dental? Medica	ıl?		(If both,	complete 5-11	for denta	ıl only.)			3372		\	NFBMC				
5. Name of Policyholder/Subs	criber in	#4 (La:	st, First,	Middle Initial,	Suffix)			P	PATIENT INFORMATION							
								18. Relationship to Policyholder/Subscriber in #12 Above 19. Reserved For								ed For Future
6. Date of Birth (MM/DD/CCY	Y)	7. Gend	ler	8. Policyho	older/Subs	scriber ID (S	SN or ID#)	Self Spouse X Dependent Child Other								
		M	F					20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
9. Plan/Group Number		10. Pati	ent's Re	lationship to P	erson nar	med in #5		UPADHYA, SURAJ								
		Se	elf	Spouse [	Depe	ndent	Other	142 COVINGTON PLACE								
11. Other Insurance Company	/Dental	Benefit	Plan Na	me, Address,	City, State	e, Zip Code			LEWISVIL							
							,									
						2	1. Date of Birth	n (MM/E	DD/CCYY)	22. Gender	23. I	Patient ID/A	Account # (Ass	igned by Dentist)		
							01/27/200	)1		X M	F 80	5136162	2838			
RECORD OF SERVICES PROVIDED							_									
24 Procedure Date 25. Area 26. 27 Tooth Number(s) 28 Tooth 29 Pro						cedure	ure 29a. Diag. 29b.						24 5			
(MM/DD/CCYY)	of Oral Cavity	Tooth System		or Letter(s)	,	Surface	Co	de	Pointer Qty. 30. Description							31. Fee
1 11/28/2016							D867	0			PERIOD	ORTHO TX	INSTA	ALLMEN	Т	199.58
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10																
33. Missing Teeth Information	(Place a	n "X" or	n each m	issing tooth.)		3	4. Diagnosis	s Code	List Qualifier		( ICD-9 =	B; ICD-10 = AB )	)	;	31a. Other	
1 2 3 4 5	3 7	8 9	9 10	11 12 13	14 15	5 16 3	4a. Diagnos	is Cod	le(s)	Α		c			Fee(s)	
32 31 30 29 28 2	7 26	25 2	4 23	22 21 20	19 18	3 17 (	Primary dia	gnosis	in " <b>A</b> ")	В		D		(	32. Total Fee	199.58
35. Remarks																
AUTHORIZATIONS								ANG	CILLARY CI	LAIM/	TREATME	NT INFORMA	TION			
36. I have been informed of the charges for dental services								38. F	Place of Treatm			=office; 22=O/P Ho		39. Enclos	sures (Y or N)	
law, or the treating dentist of	r dental	practice	has a co	ontractual agre	ement wit	h my plan pr	ohibiting all		(Use "Place	of Servi	ce Codes for P	rofessional Claims'	")			
or a portion of such charge of my protected health info								40. I	s Treatment fo	r Ortho	dontics?		4	11. Date Ap	pliance Placed	(MM/DD/CCYY)
X SIGNATURE	ONI	FILE			11/	28/2016			No (Ski	ip 41-42	2) X Yes	(Complete 41-42	()	8/16/201	6	
Patient/Guardian Signature	)				Date	9		42. N	Months of Trea	tment	43. Repla	cement of Prosth	esis 4	14. Date of F	Prior Placemer	nt (MM/DD/CCYY)
37. I hereby authorize and dire	ect payn	nent of t	he denta	l benefits other	erwise pay	able to me,	directly	<u> </u>	21		No	Yes (Complete	e 44)			
to the below named dentis							,	45. T	Treatment Res	ulting fr	om					
X SIGNATURE	ON	FILE			11/	/28/2016		Occupational illness/injury Auto accident Other accident						nt		
Subscriber Signature					Date	9		46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State							ent State	
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not					s not	TREATING DENTIST AND TREATMENT LOCATION INFORMATION										
submitting claim on behalf of the patient or insured/subscriber.)						53. I hereby certify that the procedures as indicated by date are in progress (for procedures that requ						es that require				
48. Name, Address, City, State, Zip Code					n	multiple visits)	or have	been compl	eted.							
Kenneth M. Sadler, DD		Assoc	ciates,	PA				Ιx	Dr. Martin	n Slo	minski			11	/28/2016	
201 Charlois Boulevard Winston-Salem, NC 27								X         Dr. Martin Slominski         11/28/2016           Signed (Treating Dentist)         Date								
Williston-Salem, NC 27	103							54. NPI 1790716421 55. License Number								
								56. A	Address, City, S	State, Z	ip Code	56 St	Sa. Provido Decialty C	der Code 122	23X0400X	
49. NPI	- 1		Numbe	I	51. SSN (				Charlois Blv		100		,			
1144309410	41	51		I .	56-2132	2966				NC 27	103					
52. Phone Number (336) 331-35	500			52a. Addition Provide	nal r ID			Winston-Salem, NC 27103								

ADA American Dental Association® Dental Cla	im For	m								
HEADER INFORMATION										
1. Type of Transaction (Mark all applicable boxes)										
X Statement of Actual Services Request for Predetermination/Preautho	rization									
X EPSDT / Title XIX										
2. Predetermination/Preauthorization Number		P	OLICYHOL	DER/S	UBSCRIB	ER INFORMAT	ION (For Insu	rance Company N	lamed in #3)	
		12	2. Policyholder	/Subsc	riber Name (	Last, First, Middle	Initial, Suffix),	Address, City, Sta	te, Zip Code	
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION			JOHNSO	ν ΝΔ	SION					
3. Company/Plan Name, Address, City, State, Zip Code			1340 WO	,		N DR				
METLIFE				_	-	27105-4965				
PO BOX 981282		$\perp$								
EL PASO, TX 79998			3. Date of Birth	•	DD/CCYY)	14. Gender	.	older/Subscriber II	D (SSN or ID#)	
		_	12/25/196			X M F	0011232	400		
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave to	olank.)	_	6. Plan/Group	Numbe		7. Employer Nan	ne			
4. Dental? Medical? (If both, complete 5-11 for dental only.)		-	37302			PEPSI				
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		$\vdash$	ATIENT IN					40 0	. d 5 5 . t	
O Data of Dieth (AMAIDD)(OO)(A)		18. Relationship to Policyholder/Subscriber in #12 Above Self Spouse X Dependent Child Other  19. Reserved Fo								
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (3	SSN or ID#)	20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
9. Plan/Group Number 10. Patient's Relationship to Person named in #5										
Self Spouse Dependent	Other	JOHNSON, NASION C 1340 WOODRUFF GLEN DR								
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code		_				27105-4965				
The other modulated company/sortial sortial relation, realises, only, state, 249 code			VIII VOI OI	1 O/ \L	LIVI, INO 2	27 100-4000				
		21	1. Date of Birth	n (MM/E	DD/CCYY)	22. Gender	23. Patient I	ID/Account # (Assi	igned by Dentist)	
			11/16/200	)2		Хм П	8051401	162837		
RECORD OF SERVICES PROVIDED										
24 Procedure Date 25. Area 26. 27 Tooth Number(s) 28 Tooth	h 29. Proc	edure							04.5	
(MM/DD/CCYY) Cavity System or Letter(s) Surface	Cod	е	Pointer	Qty.		30. D	escription		31. Fee	
1 11/28/2016	D8670	)			PERIOD	ORTHO TX	INSTALLME	NT	164.00	
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	34. Diagnosis				( ICD-9 =	B; ICD-10 = AB )		31a. Other Fee(s)		
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	34a. Diagnosi		. ,	Α		c		32. Total Fee		
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 35. Remarks	(Primary diag	nosis i	in " <b>A</b> ")	В		D		32. Total Fee	164.00	
33. Remains										
AUTHORIZATIONS		ΔΝΟ	CILLARY CI	ΔIM/	TREATME	NT INFORMAT	TION			
36. I have been informed of the treatment plan and associated fees. I agree to be responsi	ible for all					=office; 22=O/P Ho		closures (Y or N)		
charges for dental services and materials not paid by my dental benefit plan, unless prolaw, or the treating dentist or dental practice has a contractual agreement with my plan process.				_		rofessional Claims"				
or a portion of such charges. To the extent permitted by law, I consent to your use and of my protected health information to carry out payment activities in connection with thi	disclosure	40. Is	s Treatment fo	r Ortho	dontics?		41. Date	Appliance Placed	(MM/DD/CCYY)	
X SIGNATURE ON FILE 11/28/2010			No (Ski	p 41-42	2) X Yes	(Complete 41-42)	8/22/2	016		
Patient/Guardian Signature Date		42. N	Months of Trea	tment	43. Repla	cement of Prosthe	esis 44. Date	of Prior Placemen	it (MM/DD/CCYY)	
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me	e. directly		18		No [	Yes (Complete	44)			
to the below named dentist or dental entity.	,	45. Treatment Resulting from								
X SIGNATURE ON FILE 11/28/2010	6	Occupational illness/injury Auto accident Other accident						nt		
Subscriber Signature Date		46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State						ent State		
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity	/ is not	TREATING DENTIST AND TREATMENT LOCATION INFORMATION								
submitting claim on behalf of the patient or insured/subscriber.)		53. I hereby certify that the procedures as indicated by date are in progress (for procedures that re-						es that require		
48. Name, Address, City, State, Zip Code		multiple visits) or have been completed.								
Kenneth M. Sadler, DDS and Associates, PA 201 Charlois Boulevard		X_	Dr. Martin					11/28/2016		
Winston-Salem, NC 27103		Signed (Treating Dentist) Date								
			NPI 17907				License Numb			
10.101		56. Address, City, State, Zip Code Specialty Code 1223X0400X								
49. NPI 50. License Number 51. SSN or TIN 1144309410 4151 56-2132966			Charlois Blvo ston-Salem, l		103					
52. Phone (236) 231 2500   52a. Additional		57. P	Phone (22			1 58	Additional C	)O3LIC		
Number (336) 331-3500 S2. Additional Provider ID		. N	Number (33	00) 33	1-3500		Additional Provider ID	JUSHC		

ADA American Dental Association® Dental Claim For	<b>m</b>								
HEADER INFORMATION									
Type of Transaction (Mark all applicable boxes)									
X Statement of Actual Services Request for Predetermination/Preauthorization									
X EPSDT / Title XIX									
2. Predetermination/Preauthorization Number	POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)								
	12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	SMITH, JODY S								
3. Company/Plan Name, Address, City, State, Zip Code	2900 PEAR ORCHARD RD								
METLIFE	YADKINVILLE, NC 27055								
PO BOX 981282	, , , , , , , , , , , , , , , , , , ,								
EL PASO, TX 79998	13. Date of Birth (MM/DD/CCYY)  14. Gender  15. Policyholder/Subscriber ID (SSN or ID#)								
	06/24/1968								
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)	16. Plan/Group Number 17. Employer Name								
4. Dental? Medical? (If both, complete 5-11 for dental only.)	0306436 US AIRWAYS								
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)	PATIENT INFORMATION								
0. Data of Distr. (MM/DD/00/00)	18. Relationship to Policyholder/Subscriber in #12 Above Use Use								
6. Date of Birth (MM/DD/CCYY)  7. Gender  8. Policyholder/Subscriber ID (SSN or ID#)	Self Spouse X Dependent Child Other								
9. Plan/Group Number 10. Patient's Relationship to Person named in #5	20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
Self Spouse Dependent Other	SMITH, MEGAN N 2900 PEAR ORCHARD RD								
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	YADKINVILLE, NC 27055								
The drief medianes company/serial serient fair fairle, radiose, only, educe, as seed	TABILITY ILLE, NO 27000								
	21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assigned by Dentist)								
	11/30/2002 M X F 805143162836								
RECORD OF SERVICES PROVIDED									
24 Procedure Date 25. Area 26. 27 Tooth Number(c) 28 Tooth 29 Pro	cedure 29a. Diag. 29b.								
(MM/DD/CCYY) of Oral Cavity System or Letter(s) Surface Co									
1 11/28/2016 D867	0 PERIOD ORTHO TX INSTALLMENT 150.00								
2									
3									
4									
5									
6									
7									
8									
9									
10									
	s Code List Qualifier (ICD-9 = B; ICD-10 = AB)  31a. Other Fee(s)								
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 34a. Diagnos	C								
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 (Primary diagrams) 35. Remarks	gnosis in "A") B D [32. Total Fee] 150.00								
33. Remarks									
AUTHORIZATIONS	ANCILLARY CLAIM/TREATMENT INFORMATION								
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all	38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) 39. Enclosures (Y or N)								
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	(Use "Place of Service Codes for Professional Claims")								
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.	40. Is Treatment for Orthodontics?  41. Date Appliance Placed (MM/DD/CCYY)								
X SIGNATURE ON FILE 11/28/2016	No (Skip 41-42) X Yes (Complete 41-42) 8/31/2016								
Patient/Guardian Signature Date	42. Months of Treatment 43. Replacement of Prosthesis 44. Date of Prior Placement (MM/DD/CCYY)								
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly	20 No Yes (Complete 44)								
to the below named dentist or dental entity.	45. Treatment Resulting from								
X SIGNATURE ON FILE 11/28/2016	Occupational illness/injury Auto accident Other accident								
Subscriber Signature Date	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	TREATING DENTIST AND TREATMENT LOCATION INFORMATION								
submitting claim on behalf of the patient or insured/subscriber.)	53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.								
48. Name, Address, City, State, Zip Code	multiple visits) of have been completed.								
Kenneth M. Sadler, DDS and Associates, PA 201 Charlois Boulevard	χ Dr Deborah F Novak 11/28/2016								
Winston-Salem, NC 27103	Signed (Treating Dentist) Date								
	54. NPI 1457441420 55. License Number 56. Address 6th Other 7th Ot								
10 100	56. Address, City, State, Zip Code Specialty Code 1223X0400X								
49. NPI 50. License Number 51. SSN or TIN 56-2132966	201 Charlois Blvd Winston-Salem, NC 27103								
52. Phone (236) 234 2500   52a. Additional	57. Phone (226) 221 2500   58. Additional								
Sz. Phone Number (336) 331-3500 Sza. Additional Provider ID	37. Prone   (336) 331-3500   38. Additional   Provider ID								

ADA American Dental Association® Dental Claim	n Forr	m								
HEADER INFORMATION										
Type of Transaction (Mark all applicable boxes)										
X Statement of Actual Services Request for Predetermination/Preauthoriza	ation									
X EPSDT / Title XIX		┸								
2. Predetermination/Preauthorization Number		_				ER INFORMA				
		12	2. Policyholder	r/Subsc	riber Name (	Last, First, Midd	le Initial,	, Suffix), Addr	ess, City, Sta	te, Zip Code
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		ا إ	MARSHA	LL, R	ANDY D					
Company/Plan Name, Address, City, State, Zip Code     METLIFE		-	1160 ERI	C SH	ELTON F	RD				
PO BOX 981282		١ ا	WESTFIE	LD, N	NC 27053	3-7328				
EL PASO, TX 79998		13	B. Date of Birth	n (MM/F	DD/CCYY)	14. Gender	15	Policyholder	/Subscriber II	D (SSN or ID#)
		- 1	08/12/196	•	,	l	-	38499592		- (,
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blar	nk.)	_	6. Plan/Group		r 1	7. Employer Na		30-33032	•	
4. Dental? Medical? (If both, complete 5-11 for dental only.)	,	_	300740			REXAM				
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		P	ATIENT IN	FORM	ATION					
									ed For Future	
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSI	N or ID#)	Use								
MF		20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
9. Plan/Group Number 10. Patient's Relationship to Person named in #5		MARSHALL, ISABELLE								
	Other	1160 ERIC SHELTON RD								
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code		WESTFIELD, NC 27053-7328								
		21	I. Date of Birth	2 (NANA/E	DICCVV)	22. Gender	22	Patient ID/A	oount # (Assi	igned by Dentist)
		- 1	08/12/200		DD/CCTT)	M X		. Falleni 15/AC )5144162	•	gried by Deriust)
RECORD OF SERVICES PROVIDED			00/12/200			X	100	70111102		
24 Procedure Date 25. Area 26. 27 Tooth Number(s) 28 Tooth	29. Proce	edure	e 29a, Diag. 29b.							
(MM/DD/CCYY) of Oral Tooth Cavity System or Letter(s) Surface	Code		Pointer	Qty.		30.	Description	on		31. Fee
1 11/28/2016	D8670				PERIOD	ORTHO TX	INST	ALLMENT	•	172.00
2										
3										
4										
5										
6	-									
			+ +							
9	+									
10										
	. Diagnosis	Code	List Qualifier		( ICD-9 =	B; ICD-10 = AB	)	3-	1a. Other	
	a. Diagnosis			A	(11111	С	,		Fee(s)	
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 (P	rimary diagr	nosis	in " <b>A</b> ")	В		D		32	2. Total Fee	172.00
35. Remarks										
AUTHORIZATIONS						NT INFORM <i>E</i>				
36. I have been informed of the treatment plan and associated fees. I agree to be responsible charges for dental services and materials not paid by my dental benefit plan, unless prohil	bited by	38. F		_		=office; 22=O/P H rofessional Claims		39. Enclosi	ures (Y or N)	
law, or the treating dentist or dental practice has a contractual agreement with my plan prol or a portion of such charges. To the extent permitted by law, I consent to your use and dis	clocura	40.1				Tolessional Claims		44. D-t- A	L. Blacca	(MMA/DD/00)()()
of my protected health information to carry out payment activities in connection with this cl	laim.	40. 18	s Treatment fo No (Ski			(Complete 41-42	- 1			(MM/DD/CCYY)
X SIGNATURE ON FILE 11/28/2016 Patient/Guardian Signature Date		42 N	Months of Trea			cement of Prosth		9/27/2016		it (MM/DD/CCYY)
		72.11	21	turiorit	No	Yes (Comple		44. Date 011	nor i laccinen	it (MINIBB/GGTT)
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, d to the below named dentist or dental entity.	irectly	45. T	reatment Res	ulting fr	om					
X SIGNATURE ON FILE 11/28/2016		Occupational illness/injury Auto accident Other accident					nt			
Subscriber Signature Date		46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State						ent State		
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is	not	TREATING DENTIST AND TREATMENT LOCATION INFORMATION								
submitting claim on behalf of the patient or insured/subscriber.)		53. I hereby certify that the procedures as indicated by date are in progress (for procedures that requires)						es that require		
48. Name, Address, City, State, Zip Code		multiple visits) or have been completed.								
Kenneth M. Sadler, DDS and Associates, PA		X_	Dr Debora					11/	/28/2016	
201 Charlois Boulevard Winston-Salem, NC 27103		Signed (Treating Dentist) Date								
		54. NPI 1457441420 55. License Number								
40 NDI		56. Address, City, State, Zip Code Specialty Code 1223X0400X								
49. NPI			Charlois Blv ston-Salem,		103					
52. Phone (236) 234 3500   52a. Additional		57. P	hone (22		1-3500	5	8. Additio	onal		
Number (336) 331-3300 Provider ID		N	lumber (33	10) 33	1-0000		Provid	der ID		

ADA American Dental Association Dental C	iaim Fori	m_								
HEADER INFORMATION										
Type of Transaction (Mark all applicable boxes)										
X Statement of Actual Services Request for Predetermination/Preau	thorization									
X EPSDT / Title XIX										
Predetermination/Preauthorization Number		PO	PLICYHOLI	DER/S	UBSCRIB	ER INFORMA	TION (Fo	r Insurance	Company N	amed in #3)
		12.	Policyholder	/Subsc	riber Name (I	_ast, First, Midd	le Initial, Sເ	uffix), Addre	ss, City, Stat	te, Zip Code
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION			OHNSON	J DE	ANNA					
3. Company/Plan Name, Address, City, State, Zip Code			44 LIVEC	,						
METLIFE		L	EXINGTO	1 .NC	NC 27295	5				
PO BOX 981282		$\vdash$								
EL PASO, TX 79998			Date of Birth	•	DD/CCYY)	14. Gender		•	Subscriber II	O (SSN or ID#)
		_	08/29/196			M X		941894		
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, lea	ve blank.)	_	Plan/Group N	Numbe		7. Employer Na		NOLOG	V	
4. Dental? Medical? (If both, complete 5-11 for dental only.)		_	104975			ORSYTHE	TECHI	NOLOG	Ť	
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		-	TIENT INF						10 Danamu	ad Car Cutura
C Date of Birth (AMA/IDD/COVV)		18.	Relationship		_	scriber in #12 A		har	Use	ed For Future
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber I	D (SSN or ID#)	Self Spouse X Dependent Child Other  20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
9. Plan/Group Number 10. Patient's Relationship to Person named in a	#5									
Self Spouse Dependent	#5 Other	JOHNSON, BRANDON 244 LIVEOAK LANE								
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip C		_	244 LIVEC LEXINGTO							
The other insurance company/bental benefit Flat Name, Address, Oity, Otate, 219 O	ouc	-	LXIIVOIC	JIN, I	10 21233					
		21.	Date of Birth	(MM/E	DD/CCYY)	22. Gender	23. Pa	atient ID/Acc	ount # (Assi	gned by Dentist)
		0	05/12/200	3		X M	F 805	1461628	34	
RECORD OF SERVICES PROVIDED										
	Tooth 29. Proce	edure	29a. Diag.	29b.		20	Description			31. Fee
(MM/DD/CCYY) Or Cavity System or Letter(s) Sur	face Code	e	Pointer Qty. 30. Description							31. Fee
1 11/28/2016	D8670				PERIOD	ORTHO TX	INSTAL	LMENT		150.00
2										
3										
4										
5										
6										
7										
8										
9										
	104.00							las	011	
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	34. Diagnosis				( ICD-9 =	B; ICD-10 = AB	)	318	a. Other Fee(s)	
	34a. Diagnosi:	•	"A"\	Α		C			Total Fee	450.00
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 35. Remarks	(Primary diag	HOSIS III	1 A)	В		D			Total Lee	150.00
33. Nemano										
AUTHORIZATIONS		ANCI	ILLARY CL	AIM/	TREATMEI	NT INFORMA	ATION			
36. I have been informed of the treatment plan and associated fees. I agree to be response		38. Pla	ace of Treatm	ent	11 (e.g. 11	=office; 22=O/P H	lospital) 3	39. Enclosui	res (Y or N)	
charges for dental services and materials not paid by my dental benefit plan, unless law, or the treating dentist or dental practice has a contractual agreement with my pl			(Use "Place of	of Service	ce Codes for P	rofessional Claims	5")			
or a portion of such charges. To the extent permitted by law, I consent to your use a of my protected health information to carry out payment activities in connection with		40. Is 7	Treatment for	r Ortho	dontics?		41.	. Date Applia	ance Placed	(MM/DD/CCYY)
X SIGNATURE ON FILE 11/28/20		[	No (Skip	o 41-42	2) X Yes (	Complete 41-42	2) 8/	/18/2016		
Patient/Guardian Signature Date		42. Mo	onths of Treat	tment	43. Replac	cement of Prosti	nesis 44.	. Date of Pri	or Placemen	t (MM/DD/CCYY)
37. I hereby authorize and direct payment of the dental benefits otherwise payable to	me, directly		26		No	Yes (Comple	te 44)			
to the below named dentist or dental entity.		45. Tre	eatment Resu	ulting fr	om					
X SIGNATURE ON FILE 11/28/20	016	[	Occupati	ional ill	ness/injury	Auto	accident		ther accider	nt
Subscriber Signature Date		46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State						nt State		
<b>BILLING DENTIST OR DENTAL ENTITY</b> (Leave blank if dentist or dental e submitting claim on behalf of the patient or insured/subscriber.)	ntity is not	TREATING DENTIST AND TREATMENT LOCATION INFORMATION								
,		53. I hereby certify that the procedures as indicated by date are in progress (for procedures that remultiple visits) or have been completed.					es that require			
48. Name, Address, City, State, Zip Code  Konnoth M. Sadler, DDS and Associates, PA		multiple visits) or nave been completed.								
Kenneth M. Sadler, DDS and Associates, PA 201 Charlois Boulevard		- '	Or. Martin						28/2016	
Winston-Salem, NC 27103		Signed (Treating Dentist)  54. NPI 1790716421  55. License Number								
			Idress, City, S			I .			X0400X	
49. NPI 50. License Number 51. SSN or TIN			Charlois Blvd		,	[S	pecialty Co	ae IZZ3	1040UA	
1144309410 4151 56-2132966			ton-Salem, N		103					
52. Phone Number (336) 331-3500   52a. Additional Provider ID		57. Ph	none umber (33	6) 33	1-3500	5	8. Additiona	al 903H	IC	
Number 17   Provider ID		NÜ	amber (50	-,			riovider	ייי סטטו		

ADA American Dental Association Dental	Claim For	m								
HEADER INFORMATION										
Type of Transaction (Mark all applicable boxes)										
X Statement of Actual Services Request for Predetermination/P	reauthorization									
X EPSDT / Title XIX										
Predetermination/Preauthorization Number		PC	OLICYHOLI	DER/S	UBSCRIBI	ER INFORMA	TION (For In	surance Company N	amed in #3)	
		12.	. Policyholder	/Subsci	riber Name (I	Last, First, Middl	e Initial, Suffix	x), Address, City, Stat	te, Zip Code	
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	N	$\Box$ ,	MORRISC	NI C	PAICC					
3. Company/Plan Name, Address, City, State, Zip Code			8561 CED	,		)				
METLIFE			WINSTON							
PO BOX 981282		Ľ	7711401014	1 O/ \L	LIVI, IVO	21 121				
EL PASO, TX 79998		13.	. Date of Birth	(MM/E	DD/CCYY)	14. Gender	15. Polic	yholder/Subscriber ID	(SSN or ID#)	
			07/23/196	5		X M	F 23735	3748		
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none	, leave blank.)	16.	. Plan/Group N	Numbe	r 1	7. Employer Na	me			
4. Dental? Medical? (If both, complete 5-11 for dental or	nly.)		0143243			CITIGROUP	)			
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		PA	PATIENT INFORMATION							
		18. Relationship to Policyholder/Subscriber in #12 Above 19. Reserved For Use								
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscrii	ber ID (SSN or ID#)	Self Spouse X Dependent Child Other								
MF		20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
9. Plan/Group Number 10. Patient's Relationship to Person named		MORRISON, CAIDEN								
Self Spouse Depende	ent Other	3561 CEDAR POST RD WINSTON SALEM, NC 27127								
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Z	ip Code	\	WINSTON	I SAL	EM, NC 2	27127				
		. Date of Birth		DD/CCYY)	22. Gender		nt ID/Account # (Assign	gned by Dentist)		
		07/28/200	5		X M	F  80513	4162833			
RECORD OF SERVICES PROVIDED										
(MM/DD/CCVV) Of Oral   Iooth   or Letter(c)	28. Tooth 29. Prod Surface Cod		29a. Diag. Pointer	29b. Qty.		30. [	Description		31. Fee	
Cavity System		$\overline{}$	Follitei	Qty.	DEDIOD	ODTUO TV	INIOTALLA	AFNIT	400.00	
1 11/28/2016	D8670	)			PERIOD	ORTHO TX	INSTALLI	VIENI	122.00	
		-								
3										
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5										
6										
7		-								
8		-								
9										
10	1							lat all		
33. Missing Teeth Information (Place an "X" on each missing tooth.)	34. Diagnosis				( ICD-9 =	B; ICD-10 = AB	)	31a. Other Fee(s)		
	16 34a. Diagnos		. ,	Α		c		32. Total Fee		
	17 (Primary diag	gnosis ir	n " <b>A</b> ")	В		D			122.00	
35. Remarks										
AUTHORIZATIONS		LANC	III ABV CI	A IBA	TDEATME	NT INFORMA	TION			
36. I have been informed of the treatment plan and associated fees. I agree to be r	esponsible for all	-	lace of Treatm			=office; 22=O/P H		Enclosures (Y or N)		
charges for dental services and materials not paid by my dental benefit plan, ur	nless prohibited by	50.11				rofessional Claims				
law, or the treating dentist or dental practice has a contractual agreement with n or a portion of such charges. To the extent permitted by law, I consent to your u	ise and disclosure	40 ls	Treatment for	r Ortho	dontics?		41 Da	ate Appliance Placed	(MM/DD/CCYY)	
of my protected health information to carry out payment activities in connection	with this claim. 3/2016	140.13	No (Skip			(Complete 41-42	.	6/2016	(WIIVI/DD/COTT)	
X SIGNATURE ON FILE 11/28 Patient/Guardian Signature Date	0/2010	42 M	lonths of Treat			cement of Prosth	.,	ate of Prior Placement	t (MM/DD/CCYY)	
			5		No	Yes (Complet			(	
<ol> <li>I hereby authorize and direct payment of the dental benefits otherwise payab to the below named dentist or dental entity.</li> </ol>	le to me, directly	45. Tr	reatment Resu	ultina fr		100 (00				
2 CIONATURE ON EUE 11/29	3/2016			-	ness/injury	Auto	accident	Other acciden	nt	
X SIGNATURE ON FILE 11/28 Subscriber Signature Date	012010	46. Date of Accident (MM/DD/CCYY)  47. Auto Accident State								
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dent	tal entity is not	TREATING DENTIST AND TREATMENT LOCATION INFORMATION								
submitting claim on behalf of the patient or insured/subscriber.)	TREATING DENTIST AND TREATMENT LOCATION INFORMATION  53. I hereby certify that the procedures as indicated by date are in progress (for procedures that rec						es that require			
48. Name, Address, City, State, Zip Code	53. I hereby certify that the procedures as indicated by date are in progress (for procedures that r multiple visits) or have been completed.									
Kenneth M. Sadler, DDS and Associates, PA										
201 Charlois Boulevard								11/28/2016 Date		
Winston-Salem, NC 27103		Signed (Treating Dentist)         Date           54. NPI         1790716421           55. License Number								
			ddress, City, S			50	Sa. Provider	1223X0400X		
49. NPI 50. License Number 51. SSN or T	TIN .	Į.	Charlois Blvd			<u> S</u>	Decially Code	1223704007		
1144309410 4151 56-213296			ton-Salem, N		103					
52. Phone Number (336) 331-3500   52a. Additional Provider ID		57. Ph	hone (33	6) 33	1-3500	58	B. Additional Provider ID	903HC		
Number (336) 331-3300 Provider ID		ı N	umber (33	-,			Frovider ID	<del>-</del>		

ADA American Dental Association® Dental C	Claim For	m									
HEADER INFORMATION											
1. Type of Transaction (Mark all applicable boxes)											
X Statement of Actual Services Request for Predetermination/Pred	authorization										
X EPSDT / Title XIX											
2. Predetermination/Preauthorization Number		PO	DLICYHOLI	DER/S	UBSCRIB	ER INFORMAT	<b>FION</b> (For Insur	ance Company N	lamed in #3)		
		12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code									
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION			GRANILLO	) FF	RIC I						
3. Company/Plan Name, Address, City, State, Zip Code			529 INVER	,							
METLIFE			VINSTON			27107					
PO BOX 981282		$\vdash$				-					
EL PASO, TX 79998			. Date of Birth	•	DD/CCYY)	14. Gender	_	older/Subscriber II	D (SSN or ID#)		
		_	07/20/1972 X M F 550337639								
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, le		_	16. Plan/Group Number 17. Employer Name								
4. Dental? Medical? (If both, complete 5-11 for dental only	.)	-	120731								
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		-	PATIENT INFORMATION								
C Data of Birth (MM/DD/COVC)		18.	_ `			scriber in #12 Ab		Use	ed For Future		
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber	r ID (SSN or ID#)	20	Self	<u> </u>		Dependent Child		0-4-			
9. Plan/Group Number 10. Patient's Relationship to Person named in	. #5	-	, ,		,	Suffix), Address,	City, State, Zip	Code			
Self Spouse Dependent		GRANILL(									
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip		_ `	529 INVEF WINSTON			27107					
The other modulated company/serial serience full reality, address, only, state, 2.p	ouc	'	vvii voi oi v	. 0/1	LIVI, INO 2	27 107					
		21.	. Date of Birth	(MM/E	DD/CCYY)	22. Gender	23. Patient I	D/Account # (Assi	igned by Dentist)		
			07/26/200	)2		X M F	8051311	62832			
RECORD OF SERVICES PROVIDED											
24 Procedure Date 25. Area 26. 27 Tooth Number(c) 28	. Tooth 29. Proc	edure	29a. Diag.	29b.		04 5					
	urface Cod		Pointer	Qty.		30. D	escription		31. Fee		
1 11/28/2016	D8670	)			PERIOD	ORTHO TX	INSTALLME	NT	140.63		
2											
3											
4											
5											
6											
7											
8											
9											
10								_			
33. Missing Teeth Information (Place an "X" on each missing tooth.)	34. Diagnosis				( ICD-9 =	B; ICD-10 = AB )		31a. Other Fee(s)			
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16			. ,	Α		с		` '			
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17	(Primary diag	inosis in	n " <b>A</b> ")	В		D		32. Total Fee	140.63		
35. Remarks											
AUTHORIZATIONS		ANC	II I ABV CI	AIM/	TDEATME	NT INFORMA	TION				
36. I have been informed of the treatment plan and associated fees. I agree to be res	ponsible for all					=office; 22=O/P Ho		closures (Y or N)			
charges for dental services and materials not paid by my dental benefit plan, unle law, or the treating dentist or dental practice has a contractual agreement with my	ss prohibited by					rofessional Claims"					
or a portion of such charges. To the extent permitted by law, I consent to your use	and disclosure	40. Is	Treatment for	r Ortho	dontics?		41. Date	Appliance Placed	(MM/DD/CCYY)		
of my protected health information to carry out payment activities in connection with X SIGNATURE ON FILE 11/28/2			No (Skip			(Complete 41-42)	l l		,		
X SIGNATURE ON FILE 11/28/2 Patient/Guardian Signature Date		42. Mo	onths of Trea	tment		cement of Prosthe	0.0.00		it (MM/DD/CCYY)		
37. I hereby authorize and direct payment of the dental benefits otherwise payable	to mo directly		20		No	Yes (Complete	∍ 44)				
to the below named dentist or dental entity.	to me, directly	45. Tre	eatment Resu	ulting fr	om						
X SIGNATURE ON FILE 11/28/2	2016		Occupat	tional ill	ness/injury	Auto a	accident	Other accider	nt		
Subscriber Signature Date		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	TRE/	ATING DEN	NTIST	AND TRE	ATMENT LOC	ATION INFO	RMATION			
submitting claim on behalf of the patient or insured/subscriber.)							date are in progr	ess (for procedure	es that require		
48. Name, Address, City, State, Zip Code		mı	ultiple visits)	or have	been comple	eted.					
Kenneth M. Sadler, DDS and Associates, PA		χſ	Dr. Martin	Slo	minski			11/28/2016			
201 Charlois Boulevard Winston-Salem, NC 27103			Signed (Treat					Date			
		54. NPI 1790716421 55. License Number									
		l	ddress, City, S		ip Code	56   Sp	a. Provider pecialty Code 1	223X0400X			
49. NPI 50. License Number 51. SSN or TIN			Charlois Blvd		103						
1144309410 4151 56-2132966 52. Phone (236) 331 3500 52a. Additional		Winston-Salem, NC 27103  57. Phone (226) 234 2500   58. Additional 003110									
52. Phone Number (336) 331-3500   52a. Additional Provider ID		تار کا الا	<sup>hone</sup> umber (33	6) 33	1-3500	58	. Additional Provider ID 9	03HC			

ADA American Dental Association® Dental Claim For	m								
HEADER INFORMATION									
Type of Transaction (Mark all applicable boxes)									
X Statement of Actual Services Request for Predetermination/Preauthorization									
X EPSDT / Title XIX									
2. Predetermination/Preauthorization Number	POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)								
	12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	JONES, NERO T								
3. Company/Plan Name, Address, City, State, Zip Code	5515 HIGHLAND TRACE CT								
METLIFE	WINSTON-SALEM, NC 27105								
PO BOX 981282	,								
EL PASO, TX 79998	13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscriber ID (SSN or ID#)								
	03/20/1974 X M F 240219507								
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)	16. Plan/Group Number 17. Employer Name								
4. Dental? Medical? (If both, complete 5-11 for dental only.)	300740   REXAM								
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)	PATIENT INFORMATION								
0 Date of District (MM/DD/00/00)	18. Relationship to Policyholder/Subscriber in #12 Above  19. Reserved For Future Use  Use								
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN or ID#)	Self Spouse X Dependent Child Other								
9. Plan/Group Number 10. Patient's Relationship to Person named in #5	20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
Self Spouse Dependent Other	DIXON, GWENYTH J								
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	5515 HIGHLAND TRACE CT WINSTON-SALEM, NC 27105								
The other medianice company/bental benefit har raine, hadress, only, eace, 2.p code	WING FOR-OALLIN, NO 27 100								
	21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assigned by Dentist)								
	05/31/2003 MXF 805127162831								
RECORD OF SERVICES PROVIDED									
24. Procedure Date of Oral Tooth 27. Tooth Number(s) 28. Tooth 29. Proc	edure 29a. Diag. 29b. 30 Description 34 Fee								
(MM/DD/CCYY) of Oral Cavity System or Letter(s) Surface Coc	le Pointer Qty. 30. Description 31. Fee								
1 11/28/2016 D8670	PERIOD ORTHO TX INSTALLMENT 150.00								
2									
3									
4									
5									
6									
7									
8									
9									
22 Missing Total Information (Discours (W. an each missing Asath.)	Code List Qualifier (ICD-9 = B: ICD-10 = AB.) 31a. Other								
33. Missing Teeth Information (Place an "X" on each missing tooth.)  34. Diagnosis  1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 34a. Diagnos	Fee(s)								
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 (Primary diag	N								
35. Remarks	nosis in "A") B D   32.   Iotal Fee   150.00								
AUTHORIZATIONS	ANCILLARY CLAIM/TREATMENT INFORMATION								
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all	38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) 39. Enclosures (Y or N)								
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	(Use "Place of Service Codes for Professional Claims")								
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.	40. Is Treatment for Orthodontics?  41. Date Appliance Placed (MM/DD/CCYY)								
X SIGNATURE ON FILE 11/28/2016	No (Skip 41-42) X Yes (Complete 41-42) 6/23/2016								
Patient/Guardian Signature Date	42. Months of Treatment 43. Replacement of Prosthesis 44. Date of Prior Placement (MM/DD/CCYY)								
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly	18 No Yes (Complete 44)								
to the below named dentist or dental entity.	45. Treatment Resulting from								
X SIGNATURE ON FILE 11/28/2016	Occupational illness/injury Auto accident Other accident								
Subscriber Signature Date	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.)	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.								
48. Name, Address, City, State, Zip Code									
Kenneth M. Sadler, DDS and Associates, PA 201 Charlois Boulevard	X Dr Deborah F Novak 11/28/2016								
Winston-Salem, NC 27103	Signed (Treating Dentist)         Date           54. NPI 1457441420         55. License Number								
	50.5.11								
49. NPI 50. License Number 51. SSN or TIN	56. Address, City, State, Zip Code Specialty Code 1223X0400X								
1144309410 4151 56-2132966	Winston-Salem, NC 27103								
52. Phone (226) 224 2500   52a. Additional	57. Phone (336) 331-3500   58. Additional Provider ID								
Number (336) 331-3300 Provider ID	Number (336) 331-3300 Provider ID								

ADA American Dental Association® Dental Claim F	-orm								
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					ER INFORMAT				
	1	12. Policyholder	/Subsc	riber Name (	Last, First, Middle	e Initial, Su	uffix), Address	, City, Stat	e, Zip Code
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		BRADSHA	4W, F	ROBIN G	i				
Company/Plan Name, Address, City, State, Zip Code     METLIFE		222 BEEC	CHWC	OOD CIF	CLE				
PO BOX 981282		WINSTON	I SAL	EM, NC	27105				
EL PASO, TX 79998	- 1	13. Date of Birth	(MM/E	DD/CCYY)	14. Gender	15. Pc	Policyholder/Subscriber ID (SSN or ID#)		
		03/12/195	•	,	M X F	- 1	960520		(,
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)	1	16. Plan/Group Number 17. Employer Name							
4. Dental? Medical? (If both, complete 5-11 for dental only.)		302747							
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)	, i	PATIENT IN	FORM	ATION					
	1	18. Relationship	to Poli	icyholder/Su	oscriber in #12 Ab	oove	1:		ed For Future
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN or	ID#)	X Self	Sp	oouse	Dependent Child	d Oth	her	Use	
MF	2	20. Name (Last,	First, I	Middle Initial,	Suffix), Address,	City, State	e, Zip Code		
9. Plan/Group Number 10. Patient's Relationship to Person named in #5		BRADSHA							
Self Spouse Dependent Other		222 BEEC							
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code		WINSTON	I SAL	.⊨M, NC	2/105				
	L	21. Date of Birth	\/N/IN/I/F	DD/CCVV)	22. Gender	22 Pa	ationt ID/Accou	unt # (Assi	gned by Dentist)
	1	03/12/195		DD/CCTT)	M X F	- 1	17216283		gried by Deritist)
RECORD OF SERVICES PROVIDED		00/12/100				000	17210200		
24 Procedure Date 25. Area 26. 27 Tooth Number(s) 28 Tooth 20	9. Procedure	re 29a. Diag. 29b.							
(MM/DD/CCYY) of Oral Tooth Cavity System or Letter(s) Surface	Code	Pointer	Qty.		30. D	escription		31. Fee	
1 11/28/2016 D	8670			PERIOD	ORTHO TX	INSTAL	LMENT		200.00
2									
3									
4									
5									
6									
7									
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10									
	anosis Code	e List Qualifier		( ICD-9 =	B; ICD-10 = AB )		31a	Other	
	iagnosis Co		<u>ш</u> А	(100-0-	C			Fee(s)	
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 (Primar	ry diagnosis	s in "A")	В		0		32. To	otal Fee	200.00
35. Remarks									
AUTHORIZATIONS	AN	ICILLARY CI	LAIM/	TREATME	NT INFORMA	TION			
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for a charges for dental services and materials not paid by my dental benefit plan, unless prohibited			_		=office; 22=O/P Ho		39. Enclosures	S (Y or N)	
law, or the treating dentist or dental practice has a contractual agreement with my plan prohibitir or a portion of such charges. To the extent permitted by law, I consent to your use and disclosu	ng all				Professional Claims"				
of my protected health information to carry out payment activities in connection with this claim.	40.	Is Treatment fo			(OI-t- 44 40)	.		ce Placed	(MM/DD/CCYY)
X SIGNATURE ON FILE 11/28/2016	_	No (Ski			(Complete 41-42)		0/26/2016	Discourse	L (MANA/DD/COVA)
Patient/Guardian Signature Date	42.	Months of Trea	tment	43. Repla	Yes (Complete		. Date of Prior	Placemen	t (MM/DD/CCYY)
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directl to the below named dentist or dental entity.		Treatment Res	ultina fr		res (Complete	3 44)			
	1		-	ness/injury	Auto a	accident	Oth	er accider	ıt
X SIGNATURE ON FILE 11/28/2016 Subscriber Signature Date	— <del> </del> 46.	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	_		,		ATMENT LOC	CATION			
submitting claim on behalf of the patient or insured/subscriber.)					as indicated by				es that require
48. Name, Address, City, State, Zip Code		multiple visits) or have been completed.							
Kenneth M. Sadler, DDS and Associates, PA	Ιx	Dr Debora	ah F l	Novak			11/28	3/2016	
201 Charlois Boulevard Winston-Salem, NC 27103		Signed (Trea	ting De	ntist)				ate	
		<sup>NPI</sup> 14574				. License N			
		Address, City, S		ip Code	56   Sp	a. Provide ecialty Co	er de 1223X	0400X	
49. NPI		1 Charlois Blvd nston-Salem, l		103					
50 Dhana	E7 Dhana								
Number (336) 331-3500 Sza. Additional Provider ID	157.	Number (33	so) 33	1-3500	36	Provider	· ID		

ADA American Deni	cai Asso	ociation <b>Den</b> i	tai Ciain	1 Forr	n									
HEADER INFORMATION														
Type of Transaction (Mark all apple)	icable boxes	5)												
X Statement of Actual Services		Request for Predeterminati	on/Preauthoriza	tion										
X EPSDT / Title XIX														
2. Predetermination/Preauthorization	Number				P	OLICYHOL	DER/S	UBSCRIB	ER INFORMA	TION (Fo	or Insurance	Company N	amed in #3)	
					12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code									
INSURANCE COMPANY/DEN	TAL BENI	EFIT PLAN INFORMA	TION		_ լ	MCELRO'	Y FR	RIN						
3. Company/Plan Name, Address, Ci	ity, State, Zip	p Code				308 OAK	,							
METLIFE						WINSTON	_		27107					
PO BOX 981282					$\perp$									
EL PASO, TX 79998					13	<ol><li>Date of Birth</li></ol>	n (MM/E	DD/CCYY)	14. Gender		olicyholder/	Subscriber II	(SSN or ID#)	
					┸	05/30/1976								
OTHER COVERAGE (Mark appli	icable box a	nd complete items 5-11. If r	none, leave blan	k.)	16. Plan/Group Number 17. Employer Name									
4. Dental? Medical?	(If	both, complete 5-11 for den	tal only.)		305584 NOVANT HEALTH									
5. Name of Policyholder/Subscriber i	n #4 (Last, I	First, Middle Initial, Suffix)			P/	ATIENT INF	FORM	ATION				,		
					18	8. Relationship	to Poli	_	oscriber in #12 A	bove		19. Reserve	ed For Future	
6. Date of Birth (MM/DD/CCYY)	7. Gender	8. Policyholder/Sul	bscriber ID (SSN	l or ID#)	L	Self	Sp	oouse X	Dependent Chi	ld Ot	ther			
	м	F			20	0. Name (Last,	, First, N	Middle Initial,	Suffix), Address	, City, Stat	te, Zip Code	•		
9. Plan/Group Number			MCELRO'	,		E								
	Self			ther	_	308 OAK								
11. Other Insurance Company/Denta	l Benefit Pla	an Name, Address, City, Sta	te, Zip Code			WINSTON	I SAL	EM, NC	27107					
					L					1				
						21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Ass							gned by Dentist)	
						07/18/200	)3		M X	F   805	1501628	329		
RECORD OF SERVICES PRO														
/MM/DD/CCVV) of Ora	l Tooth	<ol> <li>Tooth Number(s) or Letter(s)</li> </ol>	28. Tooth Surface	29. Proce Code		29a. Diag. Pointer	29b. Qty.		30. [	Description			31. Fee	
1 11/28/2016 Cavity	System	(-)		D8670				DEBIOD	D ORTHO TX INSTALLMENT				150.00	
2				100070				LINIOD	OKITIOTA	INOTAL	LLIVILINI		130.00	
3				<del>                                     </del>										
4				<del> </del>										
5				-										
6				-										
7				_										
8				-										
9	+ +			-										
10				<del> </del>										
33. Missing Teeth Information (Place	an "Y" on e	ach missing tooth )	24	Diagnosis	Codo	List Qualifier		(ICD 9 =	B; ICD-10 = AB	`	31	a. Other		
1 2 3 4 5 6 7	8 9			a. Diagnosis			<u> </u>	(100-3-	C	,	—— °'	Fee(s)		
32 31 30 29 28 27 26				imary diagr		:- «A»\	В				32	. Total Fee	150.00	
35. Remarks							<u> </u>		<u> </u>				130.00	
AUTHORIZATIONS		-		I	ANC	CILLARY CI	LAIM/	TREATME	NT INFORMA	TION				
36. I have been informed of the treatn					38. P	Place of Treatm	nent -	11 (e.g. 11	=office; 22=O/P H	ospital)	39. Enclosu	res (Y or N)		
charges for dental services and m law, or the treating dentist or denta						(Use "Place	of Service	ce Codes for P	rofessional Claims	")				
or a portion of such charges. To the of my protected health information					40. Is	s Treatment fo	r Ortho	dontics?		41	. Date Appli	iance Placed	(MM/DD/CCYY)	
X SIGNATURE ON			1/28/2016			No (Ski	p 41-42	2) X Yes	(Complete 41-42	2) 9,	/8/2016			
Patient/Guardian Signature		Da	ite		42. N	Months of Trea	tment	43. Repla	cement of Prosth	esis 44	. Date of Pri	ior Placemen	t (MM/DD/CCYY)	
37. I hereby authorize and direct pay	ment of the	dental benefits otherwise p	avable to me. di	rectly		33		No	Yes (Complet	te 44)				
to the below named dentist or de		derital perionic entermorp	ayabio to mo, ai		45. T	reatment Res	ulting fr	om						
X SIGNATURE ON	FILE	1.	1/28/2016			Occupat	tional ill	ness/injury	Auto	accident		Other accider	nt	
Subscriber Signature		Da		t	46. D	Date of Accider	nt (MM/	DD/CCYY)			47.	Auto Accide	nt State	
BILLING DENTIST OR DENT			dental entity is	not	TRE	EATING DE	NTIST	AND TRE	ATMENT LO	CATION	INFORM	ATION		
submitting claim on behalf of the patient or insured/subscriber.)									as indicated by	date are in	n progress (	for procedure	es that require	
48. Name, Address, City, State, Zip Code					n	nultiple visits)	or have	been compl	eted.					
Kenneth M. Sadler, DDS and Associates, PA					Х	Dr. Martin	Slo	minski			11/	28/2016		
201 Charlois Boulevard Winston-Salem, NC 27103						Signed (Trea						Date		
Williaton-Salem, NC 21 103					54. NPI 1790716421 55. License Number									
					56. Address, City, State, Zip Code 56a. Provider Specialty Code 1223X0400X									
I I	. License Nu					Charlois Blv		102	_					
	151	56-21:	32966			ston-Salem, I	NC 27	103						
52. Phone Number (336) 331-3500		57. Phone Number (336) 331-3500   58. Additional Provider ID 903HC												

ADA American Dental Association® Dental Claim For	n								
HEADER INFORMATION									
Type of Transaction (Mark all applicable boxes)									
X Statement of Actual Services Request for Predetermination/Preauthorization									
X EPSDT / Title XIX									
2. Predetermination/Preauthorization Number	POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)								
	12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	LIBUNAO, JENNIE								
3. Company/Plan Name, Address, City, State, Zip Code	1350 ROSEWOOD CT								
METLIFE	WINSTON-SALEM, NC 27103								
PO BOX 981282	, , , , , , , , , , , , , , , , , , ,								
EL PASO, TX 79998	13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscriber ID (SSN or ID#)								
	07/17/1967								
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)	16. Plan/Group Number 17. Employer Name								
4. Dental? Medical? (If both, complete 5-11 for dental only.)	305584 NOVANT HEALTH								
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)	PATIENT INFORMATION								
O Date of District (AMA/DD/COVA)	18. Relationship to Policyholder/Subscriber in #12 Above  19. Reserved For Future Use  Use								
6. Date of Birth (MM/DD/CCYY)  7. Gender  8. Policyholder/Subscriber ID (SSN or ID#)	Self Spouse X Dependent Child Other								
	20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
9. Plan/Group Number 10. Patient's Relationship to Person named in #5 Self Spouse Dependent Other	LIBUNAO, OWEN								
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	1350 ROSEWOOD CT WINSTON-SALEM, NC 27103								
The other medianes company/period periods from the manner, fractions, only, etale, 219 code	WING FOR SALEIN, NO 27 100								
	21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assigned by Dentist)								
	03/12/2004 X M F 805167162828								
RECORD OF SERVICES PROVIDED									
24. Procedure Date   25. Area   26.   27. Tooth Number(s)   28. Tooth   29. Procedure Date   26.   27. Tooth Number(s)   28. Tooth   29. Procedure Date   29	edure 29a. Diag. 29b. 30 Description 34 Fee								
(MM/DD/CCYY) of Oral Cavity System or Letter(s) Surface Code	Pointer 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 20 Mission Tooth Information (Class on W// or each mission tooth)	Code List Qualifier (ICD-9 = B; ICD-10 = AB) 31a. Other								
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 34a. Diagnosis	Fee(s)								
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 (Primary diagr									
35. Remarks	nosis in "A") B D   32.   Iotal Fee   150.00								
AUTHORIZATIONS	ANCILLARY CLAIM/TREATMENT INFORMATION								
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all	38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) 39. Enclosures (Y or N)								
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	(Use "Place of Service Codes for Professional Claims")								
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.	40. Is Treatment for Orthodontics?  41. Date Appliance Placed (MM/DD/CCYY)								
X SIGNATURE ON FILE 11/28/2016	No (Skip 41-42) X Yes (Complete 41-42) 10/19/2016								
Patient/Guardian Signature Date	42. Months of Treatment 43. Replacement of Prosthesis 44. Date of Prior Placement (MM/DD/CCYY)								
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly	22 No Yes (Complete 44)								
to the below named dentist or dental entity.	45. Treatment Resulting from								
X SIGNATURE ON FILE 11/28/2016	Occupational illness/injury  Auto accident  Other accident								
Subscriber Signature Date	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.)	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.								
48. Name, Address, City, State, Zip Code	,								
Kenneth M. Sadler, DDS and Associates, PA 201 Charlois Boulevard	X Dr Deborah F Novak 11/28/2016								
Winston-Salem, NC 27103	Signed (Treating Dentist)         Date           54. NPI 1457441420         55. License Number								
	50 5 11								
49. NPI 50. License Number 51. SSN or TIN	56. Address, City, State, Zip Code Specialty Code 1223X0400X								
1144309410 4151 56-2132966	Winston-Salem, NC 27103								
52. Phone (226) 221 2500   52a. Additional	57. Phone Number (336) 331-3500   58. Additional Provider ID								
Number (336) 331-3300 Provider ID	Number (336) 331-3300 Provider ID								

ADA American Dental Association® Dental	Claim	Form									
HEADER INFORMATION											
Type of Transaction (Mark all applicable boxes)											
X Statement of Actual Services Request for Predetermination/P	Preauthorization	n									
X EPSDT / Title XIX											
2. Predetermination/Preauthorization Number			POLICYHOL	DER/S	UBSCRIBI	ER INFORMATI	ON (For Insura	nce Company N	amed in #3)		
			<ol><li>Policyholder</li></ol>	/Subsc	riber Name (I	_ast, First, Middle I	nitial, Suffix), Ad	ldress, City, Sta	te, Zip Code		
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATIO	N		FLETCHE	R D	ΔΝΙΕΙ Δ						
3. Company/Plan Name, Address, City, State, Zip Code			132 MOUI	,		OWLANE					
METLIFE			KING, NC								
PO BOX 981282		L									
EL PASO, TX 79998		Ι'	13. Date of Birth	•	DD/CCYY)	14. Gender	15. Policyholo	ler/Subscriber II	O (SSN or ID#)		
			01/10/197								
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none			16. Plan/Group Number 17. Employer Name								
4. Dental? Medical? (If both, complete 5-11 for dental of	only.)		138847 T E CONNECTIVITY LTD								
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		- F	PATIENT INFORMATION								
C Data of Birth (MM/DD/COVC)					_	scriber in #12 Abo		Use	ed For Future		
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscri	iber ID (SSN o	·	Self	<u> </u>		Dependent Child	Other				
9. Plan/Group Number 10. Patient's Relationship to Person name					Suffix), Address, C	ity, State, Zip O	ode				
Self Spouse Depende	er	FLETCHE			NA/ I A NIE						
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Z		132 MOUI KING, NC			W LANE						
The other modulated company/serial serience full reality, address, only, otale, 2	ip oode		Kiivo, Ivo	2102	- '						
		t	21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assign						gned by Dentist)		
		06/09/2001 XM F 805085162827									
RECORD OF SERVICES PROVIDED											
24 Procedure Date 25. Area 26. 27 Tooth Number(s)	28. Tooth	29. Procedure	e 29a. Diag.	29b.		O Providence					
(MM/DD/CCYY) of Oral Cavity System or Letter(s)	Surface	Code	Pointer	Qty.		30. Des	31. Fee				
1 11/28/2016		D8670			PERIOD	ORTHO TX II	133.34				
2											
3											
4											
5											
6											
7											
8											
9											
10											
33. Missing Teeth Information (Place an "X" on each missing tooth.)			le List Qualifier		( ICD-9 =	B; ICD-10 = AB )		31a. Other Fee(s)			
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15		Diagnosis Co	. ,	Α		с		32. Total Fee			
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 35. Remarks	17 (Prima	ary diagnosi	s in "A")	В		D		32. Total Fee	133.34		
55. Remarks											
AUTHORIZATIONS		IΔN	ICII I ARY CI	ΔIM/	TREATME	NT INFORMAT	ION				
36. I have been informed of the treatment plan and associated fees. I agree to be	responsible for					=office; 22=O/P Hos		osures (Y or N)			
charges for dental services and materials not paid by my dental benefit plan, u law, or the treating dentist or dental practice has a contractual agreement with r		d by		_		ofessional Claims")					
or a portion of such charges. To the extent permitted by law, I consent to your of my protected health information to carry out payment activities in connection	use and disclos	sure 40	Is Treatment fo	r Ortho	dontics?		41. Date A	opliance Placed	(MM/DD/CCYY)		
1 11	8/2016	"	No (Ski	p 41-42	2) X Yes (	Complete 41-42)	2/17/20	16			
Patient/Guardian Signature Date	0,2010	42.	Months of Trea	tment	43. Replac	cement of Prosthes			t (MM/DD/CCYY)		
37. I hereby authorize and direct payment of the dental benefits otherwise payab	ole to me direc	stlv.	17		No	Yes (Complete	14)				
to the below named dentist or dental entity.	ole to file, direc		Treatment Resi	ulting fr	om						
X SIGNATURE ON FILE 11/2	8/2016		Occupat	tional ill	ness/injury	Auto ac	cident	Other accider	nt		
Subscriber Signature Date		46.	46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State								
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or den	ntal entity is not	TR	REATING DE	NTIST	AND TRE	ATMENT LOCA	TION INFOR	MATION			
submitting claim on behalf of the patient or insured/subscriber.)					as indicated by da	te are in progres	ss (for procedure	es that require			
48. Name, Address, City, State, Zip Code		multiple visits) or have been completed.									
Kenneth M. Sadler, DDS and Associates, PA	l x	Dr. Martin				1	1/28/2016				
201 Charlois Boulevard Winston-Salem, NC 27103								Date			
,		54. NPI 1790716421 55. License Number  56. Address City State 7in Code 56a. Provider 4202004000									
Lance Lance		_	Address, City, S		ip Code	Spe	cialty Code 12	23X0400X			
49. NPI 50. License Number 51. SSN or 1144309410 4151 56-21329			1 Charlois Blvo nston-Salem, I		103						
FO Dhana	.00		Dhana			158 /	Additional 00	0110			
Number (336) 331-3500 S2a. Additional Provider ID		37.	Number (33	6) 33	1-3500	36.7	Additional Provider ID 90	ЗНС			

ADA American Dental Association® Dental Claim For	m								
HEADER INFORMATION									
Type of Transaction (Mark all applicable boxes)									
X Statement of Actual Services Request for Predetermination/Preauthorization									
X EPSDT / Title XIX									
2. Predetermination/Preauthorization Number	POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named	d in #3)							
	12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zi	p Code							
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	MILLS, PIPER								
3. Company/Plan Name, Address, City, State, Zip Code	1394 STONEGATE DRIVE								
METLIFE	WINSTON-SALEM, NC 27107-9693								
PO BOX 981282	, , , , , , , , , , , , , , , , , , ,								
EL PASO, TX 79998	13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscriber ID (SS	SN or ID#)							
	11/26/1972								
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)	16. Plan/Group Number 17. Employer Name								
4. Dental? Medical? (If both, complete 5-11 for dental only.)	305584 N								
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)	PATIENT INFORMATION	- F. t							
0. Data of Distr. (MM/DD/00/00)	18. Relationship to Policyholder/Subscriber in #12 Above Use Use	or Future							
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN or ID#)	Self Spouse X Dependent Child Other								
9. Plan/Group Number 10. Patient's Relationship to Person named in #5	20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
Self Spouse Dependent Other	MILLS, BRADEN P								
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	1394 STONEGATE DR WINSTON SALEM, NC 27107-9693								
11. Other insurance company/bental benefit i fair warne, Address, Oity, Otate, 2ip code	WINGTON GALLINI, NG 27 107-3030								
	21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assigned	by Dentist)							
	10/02/2001 XM F 805076162826								
RECORD OF SERVICES PROVIDED									
24 Procedure Date 25. Area 26. 27 Tooth Number(e) 28 Tooth 29 Proc	edure 29a, Diag. 29b.								
(MM/DD/CCYY) of Oral Tooth Cavity System or Letter(s) Surface Coc		31. Fee							
1 11/28/2016 D8670	PERIOD ORTHO TX INSTALLMENT	150.00							
2									
3									
4									
5									
6									
7									
8									
9									
10									
	Code List Qualifier (ICD-9 = B; ICD-10 = AB)  31a. Other Fee(s)								
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 34a. Diagnos	00 7445								
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 (Primary diagrams) (Primary diagrams) 35. Remarks	Inosis in "A") B D 32. Iotal Fee	150.00							
33. Remarks									
AUTHORIZATIONS	ANCILLARY CLAIM/TREATMENT INFORMATION								
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all	38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) 39. Enclosures (Y or N)								
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	(Use "Place of Service Codes for Professional Claims")								
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.	40. Is Treatment for Orthodontics?  41. Date Appliance Placed (MM.	I/DD/CCYY)							
X SIGNATURE ON FILE 11/28/2016	No (Skip 41-42) X Yes (Complete 41-42) 1/7/2016								
Patient/Guardian Signature Date	42. Months of Treatment 43. Replacement of Prosthesis 44. Date of Prior Placement (MM	//DD/CCYY)							
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly	13 No Yes (Complete 44)								
to the below named dentist or dental entity.	45. Treatment Resulting from								
X SIGNATURE ON FILE 11/28/2016	Occupational illness/injury Auto accident Other accident								
Subscriber Signature Date	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	TREATING DENTIST AND TREATMENT LOCATION INFORMATION								
submitting claim on behalf of the patient or insured/subscriber.)	53. I hereby certify that the procedures as indicated by date are in progress (for procedures the multiple visits) or have been completed.	at require							
48. Name, Address, City, State, Zip Code	multiple visits) of have been completed.								
Kenneth M. Sadler, DDS and Associates, PA 201 Charlois Boulevard	χ_Dr Deborah F Novak 11/28/2016								
Winston-Salem, NC 27103	Signed (Treating Dentist)  Date								
	54. NPI 1457441420								
10 100	Specialty Code 1223X0400X								
49. NPI 50. License Number 51. SSN or TIN 1144309410 4151 56-2132966	201 Charlois Blvd Winston-Salem, NC 27103								
52. Phone (226) 224 2500   52a. Additional	E7 Dhana								
Sz. Phone Number (336) 331-3500 Sz. Additional Provider ID	Number (336) 331-3500 St. Additional Provider ID								

ADA American Denta	ai Associ	ation <b>Dent</b>	ai Ciain	n Forr	n									
HEADER INFORMATION														
Type of Transaction (Mark all application)	able boxes)													
X Statement of Actual Services	Requ	est for Predeterminatio	n/Preauthoriza	tion										
X EPSDT / Title XIX														
2. Predetermination/Preauthorization N	lumber				P	OLICYHOLI	DER/S	UBSCRIB	ER INFORMA	TION (Fo	or Insuranc	ce Company N	lamed in #3)	
					12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code									
INSURANCE COMPANY/DENTA	AL BENEFIT	PLAN INFORMAT	ION		⅃ .	HUNTER,	THO	MAS F						
3. Company/Plan Name, Address, City,	, State, Zip Cod	le				297 JU LE								
METLIFE					\	WINSTON	I SAL	EM. NC	27107-899	5				
PO BOX 981282					$\perp$									
EL PASO, TX 79998						3. Date of Birth	,	DD/CCYY)	14. Gender	- I	-		D (SSN or ID#)	
					09/11/1969 X M F 239396839									
OTHER COVERAGE (Mark applica				ık.)	16. Plan/Group Number 17. Employer Name									
4. Dental? Medical?		complete 5-11 for denta	al only.)		143343 PIEDMONT NATURAL GAS									
5. Name of Policyholder/Subscriber in	#4 (Last, First,	Middle Initial, Suffix)			-	ATIENT INF						10 Dans	ad Can Cutura	
6. Date of Birth (MM/DD/CCYY) 7	7. Gender	10000000	" 10 (00)		18	8. Relationship Self			oscriber in #12 A Dependent Chi		ther	Use	ed For Future	
o. Date of Bil (if (WIW/DD/CC11)	M F	8. Policyholder/Sub	scriber ID (SSN	N or ID#)	20				Suffix), Address			<u> </u>		
9. Plan/Group Number 1		  ationship to Person na	med in #5		-				Sullix), Address	s, City, Stat	ie, zip coc	ue		
	ther		HUNTER, 297 JU LE											
11. Other Insurance Company/Dental E	Self Enefit Plan Na				-1				27107-8995					
, ,		•	-					,	2230					
					21	21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (					ccount # (Assi	gned by Dentist)		
						09/17/2001					2825			
RECORD OF SERVICES PROVI	DED													
24. Procedure Date 25. Area of Oral	26. Tooth	7. Tooth Number(s)	28. Tooth	29. Proce		29a. Diag.	29b.		30. Description 31				31. Fee	
	System	or Letter(s)	Surface	Code		Pointer	Qty.	250100	·				133.20	
1 11/28/2016				D8670				PERIOD	IOD ORTHO TX INSTALLMENT					
2				1										
3				1										
4														
5														
6				+										
8				+		+								
9														
10														
33. Missing Teeth Information (Place ar	n "X" on each m	nissing tooth )	34	Diagnosis (	Code	List Qualifier		(ICD-9 =	B; ICD-10 = AB	)	3	31a. Other		
1 2 3 4 5 6 7	8 9 10			a. Diagnosis			<u></u>	(	C	,		Fee(s)		
32 31 30 29 28 27 26	25 24 23	22 21 20 19 1		imary diagr		: "A"\	В					32. Total Fee	133.20	
35. Remarks						<u> </u>			<u> </u>					
AUTHORIZATIONS					ANC	CILLARY CL	LAIM/	TREATME	NT INFORM <i>E</i>	TION				
<ol> <li>I have been informed of the treatme charges for dental services and mat</li> </ol>					38. F	Place of Treatm			=office; 22=O/P H	' '	39. Enclos	sures (Y or N)		
law, or the treating dentist or dental portion of such charges. To the	oractice has a c	ontractual agreement wi	th my plan proh	ibiting all		(Use "Place o	of Service	ce Codes for P	rofessional Claims					
of my protected health information to					40. Is	s Treatment for					. Date App	oliance Placed	(MM/DD/CCYY)	
X SIGNATURE ON F	ILE		/28/2016			No (Skip			(Complete 41-42		/12/201			
Patient/Guardian Signature		Dat	e		42. N	Months of Treat	tment	I — ' -	cement of Prosth		. Date of F	Prior Placemen	t (MM/DD/CCYY)	
37. I hereby authorize and direct paymento the below named dentist or denta		l benefits otherwise pa	yable to me, di		45. T	14		No	Yes (Comple	te 44)				
	•		10010010		45. I	Freatment Resu	-		☐ Auto	annidant		Othor agaider	nt.	
X SIGNATURE ON F Subscriber Signature	ILE	11 Dat	/28/2016	ŀ	Occupational illness/injury									
BILLING DENTIST OR DENTAL	ENTITY (1.2			_			`		ATMENT LO	CATION			ili State	
submitting claim on behalf of the patien			derital entity is i	- 1									es that require	
48. Name, Address, City, State, Zip Code					53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.									
Kenneth M. Sadler, DDS and Associates, PA					x Dr. Martin Slominski 11/28/2016									
201 Charlois Boulevard					^_	Signed (Treat						Date		
Winston-Salem, NC 27103				ľ	54. NPI 1790716421 55. License Number									
						Address, City, S			5 8	6a. Provide pecialty Co	er ode 122	23X0400X		
l I	icense Numbe					Charlois Blv		100	ے	. , , ,				
1144309410 415	1	56-213	2966			ston-Salem, I	NC 27	103						
<sup>52. Phone</sup> (336) 331-3500		52a. Additional Provider ID		I	57. F	Phone Number (33	36) 33	1-3500	5	<ol><li>Addition Provider</li></ol>	al r ID 903	BHC		

ADA American Dental Association Denta	i Ciaim Fo	rm									
HEADER INFORMATION											
Type of Transaction (Mark all applicable boxes)											
X Statement of Actual Services Request for Predetermination/	Preauthorization										
X EPSDT / Title XIX											
2. Predetermination/Preauthorization Number		P	POLICYHOLI	DER/S	UBSCRIB	ER INFORMA	TION (For Ins	urance Company N	lamed in #3)		
		1	12. Policyholder	/Subsc	riber Name (	Last, First, Middle	e Initial, Suffix),	Address, City, Sta	te, Zip Code		
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	ON		ZUIDEMA	KF\	/IN A						
3. Company/Plan Name, Address, City, State, Zip Code			923 RIDGI	,		F					
METLIFE			LEWISVIL			_					
PO BOX 981282		L									
EL PASO, TX 79998		1	13. Date of Birth	(MM/E	DD/CCYY)	14. Gender		nolder/Subscriber II	O (SSN or ID#)		
			01/13/1969 X M F 001085584								
OTHER COVERAGE (Mark applicable box and complete items 5-11. If non	e, leave blank.)	1	16. Plan/Group Number 17. Employer Name								
4. Dental? Medical? (If both, complete 5-11 for dental	only.)		83010 PEPSICO								
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		P	PATIENT INF	ORM	ATION						
		1			. —	scriber in #12 Al		19. Reserv	ed For Future		
6. Date of Birth (MM/DD/CCYY)  7. Gender  8. Policyholder/Subsc	riber ID (SSN or ID#	· —	Self	<u> </u>		Dependent Chil					
		2	20. Name (Last,	First, I	Middle Initial,	Suffix), Address	, City, State, Zip	Code			
9. Plan/Group Number 10. Patient's Relationship to Person nam		ZUIDEMA									
Self Spouse Depend			923 RIDGI								
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State,	Zip Code		LEWISVIL	LE, ľ	NC 27023						
			24 D-4 ( D:-4)	/A AB A/E	20,000,00	00.0	00 Deticate	ID/A + # /A :			
			21. Date of Birth 10/03/200	-	DD/CCYY)	22. Gender	- 1	ID/Account # (Assi	gned by Dentist)		
			10/03/200	' 1			003002	102024			
RECORD OF SERVICES PROVIDED  25. Area 26. 27. Trath Number(s)	<u> </u>										
24. Procedure Date (MM/DD/CCYY) of Oral Tooth (Cavity System) 27. Tooth Number(s) or Letter(s)		rocedure Code	29a. Diag. Pointer	29b. Qty.		30. Description 3					
1 11/28/2016	D86	70			PERIOD	ORTHO TX INSTALLMENT					
2		10			LITTOD	DD ORTHO TX INSTALLMENT 1					
3											
4											
5			+ +								
6											
7											
8											
9			+ +								
10											
33. Missing Teeth Information (Place an "X" on each missing tooth.)	34. Diagno	sis Code	e List Qualifier		( ICD-9 =	B; ICD-10 = AB )	)	31a. Other			
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15	16 34a. Diagr			 A		С		Fee(s)			
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18	17 (Primary d	iagnosis	s in " <b>A</b> ")	В		D		32. Total Fee	115.00		
35. Remarks								- 1			
AUTHORIZATIONS		AN	ICILLARY CL	AIM/	TREATME	NT INFORMA	TION				
36. I have been informed of the treatment plan and associated fees. I agree to be charges for dental services and materials not paid by my dental benefit plan,		38. I	Place of Treatm			=office; 22=O/P Ho		nclosures (Y or N)			
law, or the treating dentist or dental practice has a contractual agreement with	my plan prohibiting	all	(Use "Place of	of Servi	ce Codes for P	rofessional Claims'	"				
or a portion of such charges. To the extent permitted by law, I consent to your of my protected health information to carry out payment activities in connection		40.	Is Treatment for				- 1	e Appliance Placed	(MM/DD/CCYY)		
X SIGNATURE ON FILE 11/2	28/2016	. L	No (Skip	41-42		(Complete 41-42		/2015			
Patient/Guardian Signature Date		42.1	Months of Treat	tment	I — ' -	cement of Prosth		e of Prior Placemen	t (MM/DD/CCYY)		
37. I hereby authorize and direct payment of the dental benefits otherwise paya	able to me, directly	┖	5		No	Yes (Complete	e 44)				
to the below named dentist or dental entity.		45.	Treatment Resu	-							
X	28/2016	.			ness/injury	Auto	accident	Other accider			
Subscriber Signature Date		46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State									
<b>BILLING DENTIST OR DENTAL ENTITY</b> (Leave blank if dentist or de submitting claim on behalf of the patient or insured/subscriber.)	ntal entity is not	_				ATMENT LO					
The state of the s		I hereby certify multiple visits) of				date are in prog	gress (for procedure	es that require			
48. Name, Address, City, State, Zip Code  Kenneth M. Sadler, DDS and Associates, PA		, ,		·							
Kenneth M. Sadler, DDS and Associates, PA 201 Charlois Boulevard		X Dr. Martin Slominski 11/28/2016 Signed (Treating Dentist) Date									
Winston-Salem, NC 27103		54				5.5	5. License Numi	Date			
		54. NPI         1790716421         55. License Number           56. Address, City, State, Zip Code         56a. Provider Specialty Code         1223X0400X									
49. NPI 50. License Number 51. SSN or	·TIN	_	Address, City, S 1 Charlois Blvo		.p code	S	pecialty Code	1223XU4UUX			
1144309410 4151 56-21329			nston-Salem, N		103						
52. Phone (226) 224 2500   52a. Additional	<del>-</del>	57. 1	Phone (33	6) 33	1-3500	58	B. Additional Provider ID	003HC			
Number (336) 331-3500 Provider ID			Number (33	<i>u)</i> 33	1-0000		Provider ID	JUJUU			

	41	<b>DA</b> American L	ent	al As	SOCI	ation®	Dent	al Cla	aim F	orm									
[	Н	EADER INFORMATION	1																
	1.	Type of Transaction (Mark a	II applio	able bo	xes)														
	[	X Statement of Actual Ser	vices		Requ	est for Prede	terminatio	n/Preautho	orization										
	[	X EPSDT / Title XIX																	
	2.	Predetermination/Preauthor	ization	Number							POLICYHOL	DER/S	UBSCRIB	ER INFO	RMATIO	N (For Insuran	ce Company N	lamed in #3)	
											12. Policyholder	r/Subsc	riber Name (	Last, First,	Middle Ini	itial, Suffix), Add	ress, City, Sta	ite, Zip Code	
Γ	IN	ISURANCE COMPANY	/DEN1	AL BE	NEFIT	PLAN INF	ORMAT	ION			ELLIS, JU	II IE							
	3.	Company/Plan Name, Addre	ess, Cit	y, State,	Zip Cod	е					3720 BEE			ΡD					
		METLIFE									WINSTON	_			0778				
		PO BOX 981282									VVIIVOTOI	N OAL	LLIVI, INC	21 100-	3110				
		EL PASO, TX 7999	8							ĺ	13. Date of Birth	n (MM/E	DD/CCYY)	14. Gend	der	15. Policyholder/Subscriber ID (SSN or ID#)			
											01/05/1969						)		
- [	0	THER COVERAGE (Mar	k applic	able bo	x and co	mplete items	5-11. If n	one, leave	blank.)		16. Plan/Group Number 17. Employer Name								
	4.	Dental? X Medica	l? 🗌		(If both,	complete 5-1	1 for dent	al only.)			305584 NOVANT HEALTH								
	5.	Name of Policyholder/Subso	criber in	#4 (La:	st, First,	Middle Initial	Suffix)				PATIENT IN	FORM	ATION						
		KEVIN ELLIS								Ī	18. Relationship	to Poli	icyholder/Sul	oscriber in	#12 Above	9		ed For Future	
-8 B	6.	Date of Birth (MM/DD/CCY)	Y)	7. Gend	der	8. Policyh	older/Sub	scriber ID	(SSN or ID	)#)	Self	Sp	pouse X	Depende	nt Child	Other	Use		
	(	04/08/1966		XM	F	249154	559				20. Name (Last	, First, I	Middle Initial,	Suffix), Ad	ddress, City	y, State, Zip Co	de		
	9.	Plan/Group Number		10. Pati	ent's Re	ationship to	erson na	med in #5			ELLIS, KE	ELSE	Y						
		112815		Se	elf	Spouse	X Depe	endent	Other		3720 BEE			RD					
	11	. Other Insurance Company	/Dental	Benefit	Plan Nai	me, Address,	City, Stat	e, Zip Code	е		WINSTON	N SAL	EM, NC	27105-9	9778				
		METLIFE																	
		PO BOX 981282									21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (As						igned by Dentist)		
L	EL PASO, TX 79998							01/16/2003						2823					
	RI	ECORD OF SERVICES	PROV	IDED															
	(MM/DD/CCVV) Of Oral   Iooth   or Letter(c)   Surface							Procedu						ription	31. Fee				
-		(MM/DD/CCYY)	Cavity	System		or Letter(s)		Surfac		Code	Pointer	Qty.						01.100	
-  -	1	11/28/2016							D8670				PERIOD	ORTH	O TX INS	STALLMEN <sup>-</sup>	Γ	150.00	
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-	3																		
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- 1	9																		
- 1	10																		
-  -	33	. Missing Teeth Information									de List Qualifier		( ICD-9 =	B; ICD-10	= AB )		31a. Other Fee(s)		
-  -			5 7			11 12 1		5 16	34a. Diag		• •	Α		c	:				
_ gg		32 31 30 29 28 2	7 26	25 2	23	22 21 2	) 19 1	17	(Primary	diagnos	sis in " <b>A</b> ")	В		D	)		32. Total Fee	150.00	
۱ ۵	35	. Remarks																	
-	_									La									
- 1		UTHORIZATIONS  I have been informed of the	trootm	ont nlon	and acc	naiatad faas	l agrae to	he recoon	sible for all	-	NCILLARY C						sures (Y or N)		
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		law, or the treating dentist o or a portion of such charge:								. —	). Is Treatment fo			Totocoloria	Oldinio )	144 Data An	L Diament	(MM/DD/CCVVV)	
		of my protected health infor		-	out payn	nent activities				40	No (Ski			(Complete	41 42)			I (MM/DD/CCYY)	
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ŀ	DI	ILLING DENTIST OR D	ENTA	LENT	ITV (Le	ove blank if		-	hu io not	_	REATING DE			ATMEN'	TIOCAT			SII Glate	
		bmitting claim on behalf of the					ientist or	dental entit	ty is not	- ⊢	B. I hereby certify							os that require	
ŀ	48	. Name, Address, City, State	Zin C	ode						$\dashv$	multiple visits)				ed by date	are in progress	(loi procedur	es trat require	
					ciates	PA					. Dr Daha-	ob E	Novel				12012040		
	Kenneth M. Sadler, DDS and Associates, PA 201 Charlois Boulevard			-   '	X Dr Debora Signed (Trea					11	/28/2016 Date								
	Winston-Salem, NC 27103			54. NPI 1457441420 55. License Number															
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ADA American Dental Association® Dental Cla	im For	m									
HEADER INFORMATION											
1. Type of Transaction (Mark all applicable boxes)											
X Statement of Actual Services Request for Predetermination/Preauthor	orization										
X EPSDT / Title XIX											
2. Predetermination/Preauthorization Number		P	OLICYHOL	DER/S	UBSCRIB	ER INFORMA	TION (Fo	or Insurance	Company N	lamed in #3)	
		12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code									
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		┑.			· <b>-</b>						
3. Company/Plan Name, Address, City, State, Zip Code			LILLY, RC			- DD					
METLIFE			1055 STE			DK					
PO BOX 981282		'	KING, NC	2102	<u> </u>						
EL PASO, TX 79998		13	3. Date of Birth	n (MM/E	DD/CCYY)	14. Gender	15. P	olicyholder/	Subscriber II	D (SSN or ID#)	
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4. Dental? Medical? (If both, complete 5-11 for dental only.)		1	138847		1	E CONNE	CTIVIT	Y LTD			
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		P	ATIENT IN	FORM	ATION						
		18	8. Relationship	to Poli	icyholder/Sub	scriber in #12 Al	bove			ed For Future	
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (	(SSN or ID#)	1	Self	Sp	oouse X	Dependent Chil	ld O	ther	Use		
M		20	0. Name (Last,	, First, M	Middle Initial,	Suffix), Address	, City, Stat	te, Zip Code	•		
9. Plan/Group Number 10. Patient's Relationship to Person named in #5			LILLY, BR	RAND	ON G						
Self Spouse Dependent	Other		1055 STE			DR					
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	9		KING, NC	2702	21						
		L									
		- 1	<ol> <li>Date of Birth</li> </ol>		DD/CCYY)	22. Gender	23. P	atient ID/Ac	count # (Assi	igned by Dentist)	
			01/18/199	97		X M	F  805	0951628	822		
RECORD OF SERVICES PROVIDED											
24. Procedure Date of Oral Tooth 27. Tooth Number(s) 28. Tool			29a. Diag.	29b.		30. [	Description			31. Fee	
(MINI/DD/CCYY) Cavity System or Letter(s) Surface			Pointer	Qty.							
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22 Missing Took Information (Discountify)	04 Diamaria	0-4-	List Ossellifess		(100.0 -	D- 10D 40 - AD 1		124	a. Other		
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	<ol> <li>34. Diagnosis</li> <li>34a. Diagnosi</li> </ol>			<u> </u>	(100-9=	B; ICD-10 = AB	)		Fee(s)		
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17	(Primary diag		. ,	A		c			. Total Fee	100.00	
35. Remarks	(i filliary diag	110313	"' A)	В		D			rotair co	100.00	
o. Nomano											
AUTHORIZATIONS		ANC	CILLARY CI	LAIM/	TREATME	NT INFORMA	TION				
36. I have been informed of the treatment plan and associated fees. I agree to be respons	ible for all					=office; 22=O/P H		39. Enclosu	res (Y or N)		
charges for dental services and materials not paid by my dental benefit plan, unless pr law, or the treating dentist or dental practice has a contractual agreement with my plan				_		rofessional Claims	I				
or a portion of such charges. To the extent permitted by law, I consent to your use and of my protected health information to carry out payment activities in connection with the	disclosure	40. Is	s Treatment fo	or Ortho	dontics?		41	. Date Appli	iance Placed	(MM/DD/CCYY)	
X SIGNATURE ON FILE 11/28/201			No (Ski	p 41-42	2) X Yes (	Complete 41-42	2) 3	/3/2016			
Patient/Guardian Signature Date		42. N	Months of Trea	tment	43. Replac	cement of Prosth	esis 44	. Date of Pr	ior Placemen	it (MM/DD/CCYY)	
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me	e directly		16		No	Yes (Complet	e 44)				
to the below named dentist or dental entity.	o, uncony	45. T	reatment Res	ulting fr	om						
X SIGNATURE ON FILE 11/28/201	6		Occupa	tional ill	ness/injury	Auto	accident		Other accider	nt	
Subscriber Signature Date		46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State									
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity	y is not	TRE	ATING DE	NTIST	AND TRE	ATMENT LO	CATION	INFORM	ATION		
submitting claim on behalf of the patient or insured/subscriber.)						as indicated by	date are ir	n progress (	for procedure	es that require	
48. Name, Address, City, State, Zip Code		n	nultiple visits)	or have	been comple	eted.					
Kenneth M. Sadler, DDS and Associates, PA		Х	Dr Debora	ah F l	Novak			11/	28/2016		
201 Charlois Boulevard Winston-Salem, NC 27103			Signed (Trea	iting De	ntist)				Date		
Transfort Galorit, 110 27 100		54. NPI 1457441420 55. License Number									
		56. A	Address, City, S	State, Z	ip Code	56 Si	6a. Provide pecialty Co	ode 1223	3X0400X		
49. NPI         50. License Number         51. SSN or TIN			Charlois Blv		103						
1144309410 4151 56-2132966			ston-Salem,	NC 2/	103						
52. Phone Number (336) 331-3500 52a. Additional Provider ID		57. F	Phone Number (33	36) 33	1-3500	58	<ol> <li>Addition Provider</li> </ol>	al r ID			

ADA American Dental Association® Dental Claim	m Fori	m								
HEADER INFORMATION										
Type of Transaction (Mark all applicable boxes)										
X Statement of Actual Services Request for Predetermination/Preauthoriz	zation									
X EPSDT / Title XIX										
2. Predetermination/Preauthorization Number		P	OLICYHOL	DER/S	UBSCRIB	ER INFORMAT	TION (F	or Insurance	Company N	lamed in #3)
		12	2. Policyholder	r/Subsc	riber Name (	Last, First, Middle	e Initial, S	Suffix), Addre	ess, City, Sta	te, Zip Code
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		ַ ו	DRAUGH	ы мі	CHAEL I	4				
3. Company/Plan Name, Address, City, State, Zip Code			2121 NEV	,						
METLIFE		- 1	WINSTON	_						
PO BOX 981282		$\perp$								
EL PASO, TX 79998		- 1	13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subsc							D (SSN or ID#)
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OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave bla	ank.)	16. Plan/Group Number 17. Employer Name								
4. Dental? Medical? (If both, complete 5-11 for dental only.)		┰	305584			NOVANT HE	=AL I H	1		
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		P	ATIENT IN	FORM	ATION					
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6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SS	SN or ID#)	$\vdash$	Self			Dependent Chile		Other		
		$\dashv$				Suffix), Address,	, City, Sta	ite, Zip Code	9	
9. Plan/Group Number 10. Patient's Relationship to Person named in #5 Self Spouse Dependent	Other		HALL, MA							
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	24,01	_	2121 NEV WINSTON	_		27102				
11. Other insulance company/bental benefit Flatt Name, Address, Oity, State, 219 Code			WINSTON	N OAL	LIVI, INC 2	27 103				
		21	1. Date of Birth	ı (MM/F	DD/CCYY)	22. Gender	23 P	Patient ID/Ac	count # (Assi	igned by Dentist)
		- 1	08/07/200		,	M X	- 1	51041628		<b>3</b> ,,
RECORD OF SERVICES PROVIDED									_	
24 Procedure Date 25. Area 26. 27 Tooth Number(c) 28 Tooth	29. Proce	edure	29a. Diag.	29b.						
(MM/DD/CCYY) of Oral Cavity System or Letter(s) Surface	Code		Pointer	Qty.		30. Description 3				
1 11/28/2016	D8670				PERIOD	ORTHO TX	INSTA	LLMENT		76.00
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	4a. Diagnosis		. ,	Α		c			` '	
	Primary diagr	nosis	ın " <b>A</b> ")	В		D		32	. Total Fee	76.00
35. Remarks										
AUTHORIZATIONS		ANG	CILL ABV CI	AIM/	TDEATME	NT INFORMA	TION			
36. I have been informed of the treatment plan and associated fees. I agree to be responsible	e for all					=office; 22=O/P Ho		39. Enclosu	ires (Y or N)	
charges for dental services and materials not paid by my dental benefit plan, unless proh law, or the treating dentist or dental practice has a contractual agreement with my plan pro	nibited by			_		rofessional Claims"				
or a portion of such charges. To the extent permitted by law, I consent to your use and dis	sclosure	40. Is	s Treatment fo	r Ortho	dontics?		41	I. Date Appli	iance Placed	(MM/DD/CCYY)
of my protected health information to carry out payment activities in connection with this of X SIGNATURE ON FILE 11/28/2016	ciaim.		No (Ski			(Complete 41-42)	.	5/17/2016		,
X SIGNATURE ON FILE 11/28/2016 Patient/Guardian Signature Date		42. N	Months of Trea	tment		cement of Prosth				it (MM/DD/CCYY)
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me,	directly		9		No	Yes (Complete	e 44)			
to the below named dentist or dental entity.	directly	45. T	reatment Res	ulting fr	om					
X SIGNATURE ON FILE 11/28/2016			Occupa	tional ill	ness/injury	Auto a	accident		Other accider	nt
Subscriber Signature Date		46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State								
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is	s not	TRE	ATING DE	NTIST	AND TRE	ATMENT LO	CATION	INFORM	ATION	
submitting claim on behalf of the patient or insured/subscriber.)						as indicated by	date are i	in progress (	for procedure	es that require
48. Name, Address, City, State, Zip Code		n	nultiple visits)	or have	been comple	eted.				
Kenneth M. Sadler, DDS and Associates, PA		Х	Dr Debora	ah F I	Novak			11/	28/2016	
201 Charlois Boulevard Winston-Salem, NC 27103	Į		Signed (Trea						Date	
	ļ		<sup>IPI</sup> 14574				5. License			
			ddress, City, S		ip Code	56   Sp	Sa. Provido pecialty C	er ode 1223	3X0400X	
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1144309410 4151 56-2132966 52. Phone (236) 331 3500 52a. Additional		Winston-Salem, NC 27103  57. Phone (236) 231 2500 [58. Additional								
Number (336) 331-3500 S2a. Additional Provider ID		57. P	none lumber (33	36) 33	1-3500		Provide	er ID		

F	ADA A	American L	ent	al As	socia	tion®	Dent	al Cla	aim F	orm									
	HEADER	INFORMATION	1																
	I. Type of	Transaction (Mark a	all applic	cable bo	xes)														
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											12. Policyholder	r/Subsc	riber Name (	Last, First,	Middle In	itial, Suffix), Ad	dress, City, Sta	ite, Zip Code	
Ī	NSURA	NCE COMPANY	/DENT	AL BE	NEFIT	PLAN INF	ORMAT	ION			WIII KINIC	VINI	CENT O						
- [	3. Compar	ıy/Plan Name, Addr	ess, Cit	y, State,	Zip Code						WILKINS, 2119 HO			DIVE					
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	EL P	ASO, TX 7999	8								13. Date of Birth	n (MM/E	DD/CCYY)	14. Gend		15. Policyhold	er/Subscriber I	D (SSN or ID#)	
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-g (	3. Date of	Birth (MM/DD/CCY)	Y)	7. Gend	der	8. Policyh	older/Sub	scriber ID	(SSN or II	D#)	Self	Sp	oouse X	Depende	nt Child	Other	Use		
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	0815	01		Se	elf	Spouse	X Depe	endent	Other		2504 TAN			E					
[		nsurance Company					City, Stat	e, Zip Code	е		WINSTON	N-SAL	EM, NC	27127					
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	P O BOX 2100					21. Date of Birth (MM/DD/CCYY)  22. Gender  23. Patient ID/Account # (Assigned by							igned by Dentist)						
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L	RECORE	OF SERVICES	PROV	IDED															
		Procedure Date	25. Area of Oral	26. Tooth	27.	Tooth Numb	er(s)	28. Too		. Procedur								31. Fee	
╌	<u> </u>	MM/DD/CCYY)	Cavity			or Letter(s)		Surfac		Code	Pointer Qty.  PERIOD ORTHO TX INSTALLMENT								
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l`	charge	s for dental services	and ma	aterials n	ot paid by	my dental b	enefit pla	n, unless p	rohibited b	by		_	ce Codes for F			tai) Job. Elloic			
	or a po	the treating dentist on trion of such charge:	s. To the	extent	permitted	by law, I cor	sent to yo	our use and	disclosur	<u> </u>	. Is Treatment fo					41 Date Ar	nliance Placed	(MM/DD/CCYY)	
- [,		rotected health info			out payme	ent activities		tion with th /28/201		"	No (Ski			(Complete	41-42)	3/30/20	•	(11111111111111111111111111111111111111	
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-  3		y authorize and directly below named dentise				benefits oth	erwise pa	yable to m	e, directly		. Treatment Res	ultina fr		133 (33		.,			
- [,		CICNIATURE	- 01				11	/28/201	16			-	ness/injury		Auto acci	ident	Other accide	nt	
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h		Subscriber Signature Date  BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not					tv is not	_	REATING DEI			ΔTMEN	TLOCAT						
		claim on behalf of t					acritict or	dornar orni	., 10 1101		. I hereby certify							es that require	
	8. Name, Address, City, State, Zip Code					$\dashv$	multiple visits)						. (						
- 1		B. Name, Address, City, State, Zip Code Kenneth M. Sadler, DDS and Associates, PA					V. Dr. Dohoroh E. Novels												
		arlois Boulevard								X Dr Deborah F Novak 11/28/2016 Signed (Treating Dentist) Date									
- [	vvinston	-Salem, NC 27	103							54	NPI 14574				55. Li	cense Number			
											. Address, City,				56a. F	Provider alty Code 12	23X0400X	,	
4	19. NPI		50.	License	Number		51. SSN	or TIN		20	1 Charlois Blv	d			Cobeci	any Joue 12		-	
	1144309	9410	41	51			56-213	2966		W	inston-Salem,	NC 27	103						
	2. Phone Numbe	(336) 331-35	500			52a. Additio Provid	nal er ID			57	Phone (33	36) 33	1-3500		58. Ad	dditional rovider ID			

ADA American Denta	ai Associ	ation <b>Dent</b>	ai Ciain	n Forr	n								
HEADER INFORMATION													
Type of Transaction (Mark all applic	able boxes)												
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X EPSDT / Title XIX													
2. Predetermination/Preauthorization I	Number				Р	OLICYHOL	DER/S	UBSCRIB	ER INFORMAT	TION (For	Insurance	Company N	amed in #3)
					12	2. Policyholder	r/Subsc	riber Name (	Last, First, Middle	e Initial, Suf	ffix), Addre	ess, City, Stat	te, Zip Code
INSURANCE COMPANY/DENT	AL BENEFIT	PLAN INFORMAT	ION		٦,	SMITH, LA	/ IID	^					
3. Company/Plan Name, Address, City	, State, Zip Coo	le				SWITH, LA 825 ERNE			ΡN				
METLIFE					- 1	LEXINGT(							
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OTHER COVERAGE (Mark applic	able box and co	mplete items 5-11. If n	one, leave blan	ık.)	16	6. Plan/Group	Numbe	er /	17. Employer Nar	me			
4. Dental? Medical?	(If both,	complete 5-11 for dent	al only.)			305584		1	NOVANT HE	EALTH			
5. Name of Policyholder/Subscriber in	#4 (Last, First,	Middle Initial, Suffix)			P.	ATIENT INF	FORM	ATION					
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	M F				20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
9. Plan/Group Number	10. Patient's Re	lationship to Person na	med in #5		SMITH, EMILY								
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RECORD OF SERVICES PROV	IDED												
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(MM/DD/CCYY) of Oral Cavity	Tooth System	or Letter(s)	Surface	Code		Pointer	Qty.		30. D	Description			31. Fee
1 11/28/2016				D8670				PERIOD	ORTHO TX	INSTALL	LMENT		150.00
2													
3													
4													
5													
6													
7													
8													
9													
10													
33. Missing Teeth Information (Place a	n "X" on each n	nissina tooth.)	34.	Diagnosis (	Code	List Qualifier		( ICD-9 =	B; ICD-10 = AB )	)	31:	a. Other	
1 2 3 4 5 6 7	8 9 10			a. Diagnosis			<u></u>	(	C	<u>'</u>		Fee(s)	
32 31 30 29 28 27 26	25 24 23	22 21 20 19 1		imary diagr		:- «A»\	В				32.	. Total Fee	150.00
35. Remarks							<u> </u>		<u> </u>				130.00
AUTHORIZATIONS					ANG	CILLARY CI	LAIM/	TREATME	NT INFORMA	TION			
36. I have been informed of the treatme	ent plan and ass	ociated fees. I agree to	be responsible			Place of Treatm			=office; 22=O/P Ho		9. Enclosu	res (Y or N)	
charges for dental services and ma law, or the treating dentist or dental						(Use "Place	_		rofessional Claims"				
or a portion of such charges. To the	extent permitte	d by law, I consent to yo	ur use and disc	closure	40. Is	s Treatment fo	r Ortho	dontics?		41. [	Date Appli	ance Placed	(MM/DD/CCYY)
of my protected health information to			tion with this ci /28/2016	aım.		No (Ski		_	(Complete 41-42)	.	4/2016		(
X SIGNATURE ON F Patient/Guardian Signature	-ILE	Dat			42. N	Months of Trea			cement of Prosth			or Placemen	t (MM/DD/CCYY)
						16		No	Yes (Complete		D 410 01 1 11		(
<ol> <li>I hereby authorize and direct paym to the below named dentist or dent</li> </ol>		al benefits otherwise pa	yable to me, di		45. T	Freatment Resi	ultina fr			/			
	,	11	12012016				-	ness/injury	Auto a	accident	Пс	Other accider	nt
X SIGNATURE ON I	FILE	I I	/28/2016	ŀ	46 F	<u> </u>					<u> </u>		
BILLING DENTIST OR DENTA	I ENTITY (L			_	46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State  TREATING DENTIST AND TREATMENT LOCATION INFORMATION							Tit Gtate	
submitting claim on behalf of the patie			dental entity is	- 1					as indicated by				os that require
48 Name Address City State 7in Co						nultiple visits)				uate are iri p	progress (i	ioi procedure	es triat require
	Name, Address, City, State, Zip Code enneth M. Sadler, DDS and Associates, PA				_	D. 14 .:	<u> </u>					00/0010	
201 Charlois Boulevard					X Dr. Martin Slominski 11/28/2016								
inston-Salem, NC 27103				ŀ	Signed (Treating Dentist)         Date           54. NPI         1790716421           55. License Number								
49. NPI 50. License Number 51. SSN or TIN					56. Address, City, State, Zip Code Specialty Code 1223X0400X  201 Charlois Blvd								
49. NPI 50. 1 1144309410 415		r 51. SSN 56-213				charlois Blvd ston-Salem, I		103					
F2 Phone		50-213	2000			Dhono			1.58	8. Additional	000:	10	
<sup>52. Phone</sup> Number (336) 331-3500		Provider ID			h	Number (33	so) 33	1-3500		B. Additional Provider II	D 903F	1C	

ADA American Dental Association	Dental Clain	n Forn	n								
HEADER INFORMATION											
Type of Transaction (Mark all applicable boxes)											
X Statement of Actual Services Request for Pred	letermination/Preauthoriza	ation									
X EPSDT / Title XIX											
Predetermination/Preauthorization Number			PO	LICYHOLI	DER/S	UBSCRIB	ER INFORMA	ATION (	For Insuranc	e Company N	lamed in #3)
			12.	Policyholder	/Subsc	riber Name (	Last, First, Midd	dle Initial,	Suffix), Addr	ress, City, Sta	te, Zip Code
INSURANCE COMPANY/DENTAL BENEFIT PLAN IN	FORMATION		⊒ ₽	NGLISH.	RET	SY					
3. Company/Plan Name, Address, City, State, Zip Code				40 GRAN	,						
METLIFE			1 -				27104-412	2			
PO BOX 981282											
EL PASO, TX 79998			13.	Date of Birth	(MM/E	DD/CCYY)	14. Gender	- 1	Policyholder	r/Subscriber II	D (SSN or ID#)
			0	06/01/196	3		M X	24	10233337	7	
OTHER COVERAGE (Mark applicable box and complete item	s 5-11. If none, leave blar	nk.)	-	Plan/Group I	Numbe		7. Employer Na				
4. Dental? Medical? (If both, complete 5-	-11 for dental only.)		$\perp$ 3	305584		1	NOVANT H	IEALTI	H		
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initia	al, Suffix)		PA	TIENT INF	ORM	ATION				_	
			18.	_ `			oscriber in #12 A			19. Reserv Use	ed For Future
	holder/Subscriber ID (SSI	N or ID#)	Self Spouse X Dependent Child Other								
MF			20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
9. Plan/Group Number 10. Patient's Relationship to			STANEK, ROMULUS								
Self Spouse		Other	240 GRANDVIEW DR								
11. Other Insurance Company/Dental Benefit Plan Name, Address	s, City, State, Zip Code		WINSTON SALEM, NC 27104-4122								
				21. Date of Birth (MM/DD/CCYY)   22. Gender   23. Patient ID/Account # (Assign 08/10/2001   X M F 805119162818						gned by Dentist)	
				00/10/200	, ı		N L	]	3119102	.010	
RECORD OF SERVICES PROVIDED											
24. Procedure Date (MM/DD/CCYY) and Cavity System 27. Tooth Num or Letter(s		29. Proced Code		29a. Diag. Pointer	29b. Qty.		30.	Descriptio	on		31. Fee
1 11/28/2016 System		D8670	-			PERIOD	ORTHO TX	(INST	ALL MENT	-	200.00
2		10070	$\neg$			LITTOD	011110 17	(111017	CLLIVILIAI		200.00
3			_								
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8		+	$\dashv$								
9			$\dashv$								
10			-								
33. Missing Teeth Information (Place an "X" on each missing tooth	) 34	. Diagnosis C	Code I	ist Qualifier		( ICD-9 =	B; ICD-10 = AB	:)	3	1a. Other	
1 2 3 4 5 6 7 8 9 10 11 12	·	a. Diagnosis			<u>——</u> А	(11111	C	,		Fee(s)	
32 31 30 29 28 27 26 25 24 23 22 21	20 19 18 17 (Pr	rimary diagn	osis in	ı " <b>A</b> ")	В				3:	2. Total Fee	200.00
35. Remarks							<u> </u>				200.00
AUTHORIZATIONS		1	ANCI	ILLARY CL	AIM/	TREATME	NT INFORM	ATION			
36. I have been informed of the treatment plan and associated fees			38. Pla	ace of Treatm	ent -	11 (e.g. 11	=office; 22=O/P I	Hospital)	39. Enclos	ures (Y or N)	
charges for dental services and materials not paid by my dental law, or the treating dentist or dental practice has a contractual a	greement with my plan prof	hibiting all		(Use "Place of	of Service	ce Codes for P	rofessional Claim	s")			
or a portion of such charges. To the extent permitted by law, I co of my protected health information to carry out payment activitie			40. Is	Treatment for	r Ortho	dontics?		4	41. Date App	liance Placed	(MM/DD/CCYY)
χ SIGNATURE ON FILE	11/28/2016	L		No (Skip	p 41-42	Yes	(Complete 41-4	2)	5/12/2016	3	
Patient/Guardian Signature	Date		42. Mc	onths of Trea	tment	43. Repla	cement of Prost	hesis 4	44. Date of P	rior Placemen	it (MM/DD/CCYY)
37. I hereby authorize and direct payment of the dental benefits of	therwise payable to me, di	irectly		11		No [	Yes (Comple	ete 44)			
to the below named dentist or dental entity.		- 4	45. Tre	eatment Resu	ulting fr	om					
χ SIGNATURE ON FILE	11/28/2016	L		Occupat	tional ill	ness/injury	Auto	accident	t	Other accider	nt
Subscriber Signature	Date		46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State							ent State	
BILLING DENTIST OR DENTAL ENTITY (Leave blank in	f dentist or dental entity is	not .	TRE#	ATING DEN	NTIST	AND TRE	ATMENT LO	CATIO	N INFORM	MATION	
submitting claim on behalf of the patient or insured/subscriber.)						as indicated by	date are	e in progress	(for procedure	es that require	
48. Name, Address, City, State, Zip Code		multiple visits) or have been completed.									
Kenneth M. Sadler, DDS and Associates, PA		χ Dr. Martin Slominski 11/28/2016									
201 Charlois Boulevard Winston-Salem, NC 27103	L	Signed (Treating Dentist)  Date									
				54. NPI 1790716421 55. License Number							
				56. Address, City, State, Zip Code 56a. Provider Specialty Code 1223X0400X							
49. NPI 50. License Number	51. SSN or TIN			Charlois Blvd ton-Salem, I		103					
1144309410 4151 52. Phone (336) 331 3500 52a. Additi	56-2132966						1 2	S V44iti-	onal		
52. Phone Number (336) 331-3500 52a. Additi Provi	der ID	- 1	57. Ph Nu	none umber (33	6) 33	1-3500	[5	8. Additio Provid	onal der ID 903	HC	

	١	אב American ב	enta	ai As	sociatio	on <b>Dent</b>	ai Cia	um For	<u>m</u>								
- 1		EADER INFORMATION							_								
	1.	Type of Transaction (Mark all	l applic	able bo	xes)												
		X Statement of Actual Serv	ices		Request fo	r Predetermination	n/Preautho	orization									
		X EPSDT / Title XIX															
ı	2. I	—— Predetermination/Preauthoriz	zation l	Number	,				P	OLICYHOL	DER/S	UBSCRIB	ER INFORM	ATION	N (For Insuran	ce Company N	lamed in #3)
									1	2. Policyholder	r/Subsc	riber Name	(Last, First, Mid	dle Initi	ial, Suffix), Add	dress, City, Sta	te, Zip Code
ŀ	IN	SURANCE COMPANY/	DENT	ΔL BE	NEFIT PLA	N INFORMAT	ION		┪								
- 1	_	Company/Plan Name, Addres								FRISBIE,							
		METLIFE	,,	,,,						4436 GUN							
		PO BOX 981282								WINSTON	I SAL	_EM, NC	27107				
		EL PASO, TX 79998	3						1	3. Date of Birth	- (MM/F	DD/CCVV)	14. Gender	1	15 Policyholde	ar/Subscriber II	D (SSN or ID#)
		,							Ι΄			<i>DD</i> /0011)	XM	۱- ۱			B (0011 01 1D#)
ŀ	_								٠,	10/21/197				<u>, I, </u>	05368108	0	
- 1		THER COVERAGE (Mark	$\overline{}$					blank.)	- ¹	6. Plan/Group	Numbe		17. Employer N				
ŀ	_	Dental? X Medical?				lete 5-11 for dent	al only.)		+	302448			BCD TRAV	EL			
		Name of Policyholder/Subscr	riber in	#4 (Las	st, First, Middi	e Initial, Suffix)			P	ATIENT IN	FORM	ATION					
_ 2		KRISTI FRISBIE							1	_ '	to Poli	· —	bscriber in #12		_	19. Reserv Use	ed For Future
- gg	3. I	Date of Birth (MM/DD/CCYY)	)	7. Gend	"	Policyholder/Sub	scriber ID (	(SSN or ID#)	Self Spouse X Dependent Child Other								
L	_	10/27/1969		M	X F U	36911731			20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
	9. I	Plan/Group Number				ship to Person na	_	_		FRISBIE,	FELI	CITY					
		2499690		Se	elf Sp	ouse X Dep	endent	Other		4436 GUN	/ITRE	E RD					
		Other Insurance Company/[	Dental	Benefit	Plan Name, A	ddress, City, Stat	e, Zip Code	9		WINSTON	I SAL	EM, NC	27107				
		CIGNA															
	P O BOX 188037						21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assigned							igned by Dentist)			
	CHATTANOOGA, TN 37422						11/16/2000 M X F 805030162817										
Γ	RE	CORD OF SERVICES I	PROV	IDED													
ı	П		25. Area		27. Too	th Number(s)	28. Too	th 29. Proc	edure							24 5	
L			of Oral Cavity	Tooth System		Letter(s)	Surfac	e Cod	le	Pointer	Qty.		30.	Descri	puon		31. Fee
	1	11/28/2016						D8670	)	PERIOD ORTHO TX INSTALLMENT						66.66	
Γ	2																
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⊢	-	Missing Teeth Information (F	Dlago a	n "Y" or	o o o o b missin	a tooth )		24 Diagnosis	Code	List Qualifier		(100.0 -	B; ICD-10 = AE			31a. Other	
ŀ		1 2 3 4 5 6		8 9		12 13 14	15 16	34a. Diagnosis				(100-9 -		, ,		Fee(s)	
⊢	_									-(-)	Α		c		—— h	32. Total Fee	
_g		32 31 30 29 28 27 Remarks	26	25 2	4 23 22	21 20 19	18 17	(Primary diag	110515	ш А)	В		D			JZ. TOTAL TEE	66.66
٠	50.	. Remarks															
ŀ	_	ITUODIZATIONS								011 I ABV 01			NT INFORM	<u> </u>			
- 1	_	JTHORIZATIONS  I have been informed of the	trootmo	ant plan	and accordate	d food Lagrage to	he recoons	ible for all		Place of Treatn			NT INFORM			sures (Y or N)	
	30.	charges for dental services a	and ma	terials n	ot paid by my	dental benefit pla	n, unless pi	rohibited by	30.1		_		1=office; 22=O/P Professional Claim		39. E1100	sules (1 of N)	
		law, or the treating dentist or or a portion of such charges.							40.				Totocoloriai Ciairi		14.5.4		4.0000000000000000000000000000000000000
		of my protected health inforn				activities in connec	ction with th	is claim.	40. 1	s Treatment fo			(Olate 44 )	10)			(MM/DD/CCYY)
	X,	SIGNATURE	ON F	FILE			/28/201	6		No (Ski			(Complete 41-4		6/25/201	-	
		Patient/Guardian Signature				Da	te		42. [	Months of Trea	itment	I — ' -	acement of Pros			Prior Placemen	it (MM/DD/CCYY)
	37.	I hereby authorize and direct				efits otherwise pa	yable to m	e, directly	<u> </u>	7		No	Yes (Comple	ete 44)			
		to the below named dentist	or den	tal entity	<b>/</b> .				45.	Treatment Res	-				_		
	X,	SIGNATURE	ON I	FILE			/28/201	6		Occupa	tional ill	ness/injury	Auto	accid	lent	Other accider	nt
L		Subscriber Signature				Da	te		46. l	Date of Accide	nt (MM/	DD/CCYY)				17. Auto Accide	ent State
		LLING DENTIST OR DI					dental entit	y is not	TRI	EATING DE	NTIST	AND TRE	EATMENT LO	CATI	ION INFOR	MATION	
	sur	omitting claim on behalf of the	e patie	nt or ins	surea/subscrib	er.)							s as indicated b	y date a	are in progress	s (for procedure	es that require
- 1	48.	Name, Address, City, State,	Zip Co	ode					l '	multiple visits)	or nave	been comp	ietea.				
		enneth M. Sadler, DDS	and	Assoc	ciates, PA				Ιx	Dr. Martir	ı Slo	minski			11	1/28/2016	
		201 Charlois Boulevard Winston-Salem, NC 27103					Signed (Treating Dentist)  Date										
	٧V	motori-calem, NC 27 I	55						54. 1	<sup>NPI</sup> 17907	1642	21			ense Number		
									56.	Address, City,	State, Z	ip Code		56a. Pr Special	rovider Ity Code 122	23X0400X	
Ī	19.	. NPI	50.	License	Number	51. SSN	or TIN			Charlois Blv					•		
		44309410	415	51		56-213	2966		Win	ston-Salem,	NC 27	103					
Ī	52.	Phone Number (336) 331-350	00		52a	Additional Provider ID			57.	Phone Number (33	36) 33	1-3500	!	58. Add	ditional 903	ЗНС	

ADA American Dental Association® Dental Claim	1 Forr	n								
HEADER INFORMATION										
Type of Transaction (Mark all applicable boxes)										
X Statement of Actual Services Request for Predetermination/Preauthorizat	tion									
X EPSDT / Title XIX		┸								
2. Predetermination/Preauthorization Number		$\vdash$				ER INFORMA				
		12	2. Policyholder	r/Subsc	riber Name (	Last, First, Middl	e Initial,	Suffix), Addre	ess, City, Sta	te, Zip Code
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		վ ⊦	HURT, MI	ELOD	Y L					
Company/Plan Name, Address, City, State, Zip Code     METLIFE		2	284 KONI	NOAK	( VILLAG	E CIRCLE				
PO BOX 981282		\	WINSTON	N SAL	EM, NC	27127				
EL PASO, TX 79998		13	B. Date of Birth	h (MM/F	DD/CCYY)	14. Gender	15	Policyholder	/Subscriber II	D (SSN or ID#)
		1	11/24/196	•	,	M X		2234275		- (,
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank	k.)	-	6. Plan/Group		r 1	7. Employer Na		220-727-0		
4. Dental? Medical? (If both, complete 5-11 for dental only.)	,	-	305584			NOVANT HI		Н		
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		P/	ATIENT IN	FORM	ATION					
		18	B. Relationship	to Poli	cyholder/Sub	oscriber in #12 A	bove			ed For Future
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN	l or ID#)	Self Spouse X Dependent Child Other Use								
MF		20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
9. Plan/Group Number 10. Patient's Relationship to Person named in #5		HURT, T'KYAH F								
	ther			-		E CIRCLE				
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code			WINSTON	N SAL	EM, NC	27127				
		24 Data of Birth (MM/DD/CCVV) 22 Conder 23 Patient ID/Assount # (Ass								
		21. Date of Birth (MM/DD/CCYY)   22. Gender   23. Patient ID/Account # (Ass 11/24/1999   M   X   F   805032162816						gned by Dentist)		
			11/24/1000						010	
RECORD OF SERVICES PROVIDED    25 Area   26   27 To 10 Area   20 To 10 Area	00 0		00 - B'	001	I					
24. Procedure Date (MM/DD/CCYY) 27. Tooth Number(s) 28. Tooth Cavity System 27. Tooth Number(s) 28. Tooth Surface	29. Proce Code		29a. Diag. Pointer	29b. Qty.		30. [	Description	n		31. Fee
1 11/28/2016	D8670				PERIOD	ORTHO TX	INSTA	ALLMENT		124.00
2										
3										
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7										
8										
9										
33. Missing Teeth Information (Place an "X" on each missing tooth.) 34.	Diamasia	2040	Liet Ovelifier		(100.0 =	B; ICD-10 = AB		124	1a. Other	
	. Diagnosis		List Qualifier	<u>Ш</u> А	(100-9 =	C C	)		Fee(s)	
	mary diagr		` '	В		C		32	2. Total Fee	124.00
35. Remarks			,			<u> </u>				124.00
AUTHORIZATIONS		ANC	CILLARY C	LAIM/	TREATME	NT INFORMA	TION			
36. I have been informed of the treatment plan and associated fees. I agree to be responsible charges for dental services and materials not paid by my dental benefit plan, unless prohib		38. P		_		=office; 22=O/P H		39. Enclosu	ures (Y or N)	
law, or the treating dentist or dental practice has a contractual agreement with my plan proh	ibiting all		(Use "Place	of Servi	ce Codes for P	rofessional Claims	")			
or a portion of such charges. To the extent permitted by law, I consent to your use and disc of my protected health information to carry out payment activities in connection with this cla	aim.	40. Is	s Treatment fo				- 1	11. Date Appl	iance Placed	(MM/DD/CCYY)
X SIGNATURE ON FILE 11/28/2016			No (Ski			(Complete 41-42		7/22/2015		
Patient/Guardian Signature Date		42. N	Months of Trea	atment	I — ' -	cement of Prosth		14. Date of Pr	rior Placemen	it (MM/DD/CCYY)
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, dir to the below named dentist or dental entity.		45 T	15 reatment Res	ulting fr	No L	Yes (Complet	e 44)			
·		45. 1		-		Auto	accident		Other accider	nt
X SIGNATURE ON FILE 11/28/2016 Subscriber Signature Date	ŀ	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 r	_					ATMENT LO	CATIO			- Trans
submitting claim on behalf of the patient or insured/subscriber.)						as indicated by				es that require
48. Name, Address, City, State, Zip Code		multiple visits) or have been completed.								
Kenneth M. Sadler, DDS and Associates, PA		χ Dr Deborah F Novak 11/28/2016								
201 Charlois Boulevard Winston-Salem, NC 27103		Signed (Treating Dentist) Date								
William - Odletti, NO 27 100	[	54. N	<sup>IPI</sup> 14574	14142	20			e Number		
			ddress, City,		ip Code	56 S	Sa. Provid pecialty (	der Code 1223	3X0400X	
49. NPI 50. License Number 51. SSN or TIN			Charlois Blv ston-Salem,		103					
1144309410 4151 56-2132966 52. Phone (336) 331 3500 52a. Additional			Nh			1.50	3. Additio	nal		
Number (336) 331-3500 Sza. Additional Provider ID		N	lumber (33	36) 33	1-3500		Provid	ler ID		

ADA American Dental Ass	sociation, pent	ai Ciaim	Form									
HEADER INFORMATION												
Type of Transaction (Mark all applicable boxe	es)											
X Statement of Actual Services	Request for Predetermination	n/Preauthorizati	on									
X EPSDT / Title XIX												
2. Predetermination/Preauthorization Number				POLICYHOL	DER/S	UBSCRIB	ER INFORMAT	FION (For Insu	ırance Company N	lamed in #3)		
				12. Policyholder	/Subsc	riber Name (	Last, First, Middle	e Initial, Suffix),	Address, City, Sta	te, Zip Code		
INSURANCE COMPANY/DENTAL BEN	IEFIT PLAN INFORMAT	ION		ZUIDEMA	KF\	VIN A						
3. Company/Plan Name, Address, City, State, Z	Zip Code			923 RIDG	,		F					
METLIFE				LEWISVIL			_					
PO BOX 981282												
EL PASO, TX 79998				13. Date of Birth	n (MM/E	DD/CCYY)	14. Gender	1	older/Subscriber II	D (SSN or ID#)		
				01/13/196	9		X M F	001085	584			
OTHER COVERAGE (Mark applicable box	and complete items 5-11. If n	one, leave blank	i.)	16. Plan/Group	Numbe		17. Employer Nan	ne				
4. Dental? Medical? (I	f both, complete 5-11 for dent	al only.)		83010		F	PEPSICO					
5. Name of Policyholder/Subscriber in #4 (Last	, First, Middle Initial, Suffix)			PATIENT INF	FORM	ATION						
				18. Relationship	to Poli	· —	oscriber in #12 Ab	ove	19. Reserv Use	ed For Future		
6. Date of Birth (MM/DD/CCYY) 7. Gende		scriber ID (SSN	or ID#)	Self Spouse X Dependent Child Other								
M [	F			20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
I	nt's Relationship to Person na			ZUIDEMA, ELENA								
Self			ner	923 RIDG	_							
11. Other Insurance Company/Dental Benefit P	lan Name, Address, City, Stat	e, Zip Code		LEWISVIL	LE, N	NC 27023	3					
		24 Date of Birth (MM/DD/CCVV/) 22 Courder 22 Datient ID/Account # (Accined										
		21. Date of Birth (MM/DD/CCYY)   22. Gender   23. Patient ID/Account # (Ass 12/03/2003   M   X   F   805033162815						igned by Dentist)				
				12/03/200	)3		M X F	805033	162815			
RECORD OF SERVICES PROVIDED  25. Area 26.												
24. Procedure Date of Oral Tooth	<ol> <li>Tooth Number(s) or Letter(s)</li> </ol>	28. Tooth Surface	29. Procedu Code	ıre 29a. Diag. Pointer	29b. Qty.		30. D	escription		31. Fee		
1 11/28/2016 Cavity System	(-,		D8670			DEDIOD	ORTHO TX	INICTALLMI	ENT	150.00		
2			D0070			FLIXIOD	OKITIO IX	INSTALLIVII	LINI	130.00		
3												
4												
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9												
10												
33. Missing Teeth Information (Place an "X" on a	each missing tooth \	34 [	Diagnosis Co	ode List Qualifier		   (ICD 9 =	B; ICD-10 = AB )		31a. Other			
1 2 3 4 5 6 7 8 9			Diagnosis C		<u></u>	j (10D-3 =	C		Fee(s)			
32 31 30 29 28 27 26 25 24			nary diagnos	-i- i- "A"\	^		C		32. Total Fee	150.00		
35. Remarks	20 22 21 20 10 1	(	nary aragino		В		<u> </u>		-	130.00		
AUTHORIZATIONS			I A	NCILLARY CI	LAIM/	TREATME	NT INFORMAT	TION				
36. I have been informed of the treatment plan a			or all 38	3. Place of Treatm			=office; 22=O/P Ho		nclosures (Y or N)			
charges for dental services and materials no law, or the treating dentist or dental practice h				(Use "Place	of Servi	ce Codes for P	rofessional Claims"	)				
or a portion of such charges. To the extent per of my protected health information to carry or	ermitted by law, I consent to yo	our use and disclo	osure 40	D. Is Treatment fo	r Ortho	dontics?		41. Date	Appliance Placed	(MM/DD/CCYY)		
X SIGNATURE ON FILE		/28/2016	""	No (Ski	p 41-42	2) X Yes	(Complete 41-42)	8/5/20	015			
Patient/Guardian Signature	Dat		42	2. Months of Trea	tment	43. Repla	cement of Prosthe		of Prior Placemen	t (MM/DD/CCYY)		
37. I hereby authorize and direct payment of the	e dental henefits otherwise na	vable to me, dire	ectly	8		No	Yes (Complete	44)				
to the below named dentist or dental entity.	e dental benefits otherwise pa	lyable to me, dire		5. Treatment Res	ulting fr	rom						
χ SIGNATURE ON FILE	11	/28/2016		Occupat	tional ill	Iness/injury	Auto a	ccident	Other accider	nt		
Subscriber Signature	Dat		46	6. Date of Accider	nt (MM/	/DD/CCYY)			47. Auto Accide	ent State		
BILLING DENTIST OR DENTAL ENTI	TY (Leave blank if dentist or	dental entity is n	ot <b>T</b>	TREATING DENTIST AND TREATMENT LOCATION INFORMATION								
submitting claim on behalf of the patient or insu	mitting claim on behalf of the patient or insured/subscriber.)							late are in prog	ress (for procedure	es that require		
48. Name, Address, City, State, Zip Code	. Name, Address, City, State, Zip Code				or have	e been compl	eted.					
	enneth M. Sadler, DDS and Associates, PA				x Dr. Martin Slominski 11/28/2016							
201 Charlois Boulevard					Signed (Treating Dentist)  Date							
Winston-Salem, NC 27103	Willston-Salem, NC 27 103				54. NPI 1790716421 55. License Number							
				56. Address, City, State, Zip Code 56a. Provider Specialty Code 1223X0400X								
49. NPI 50. License N				201 Charlois Blvd Winston-Salem, NC 27103								
1144309410 4151	56-213	2966			NC 27	103						
<sup>52</sup> Phone Number (336) 331-3500	52a Additional Provider ID		57	7. Phone Number (33	36) 33	1-3500	58	. Additional Provider ID	903HC			

ADA American Dental Association® Dental (	Claim For	m								
HEADER INFORMATION		$\Box$								
Type of Transaction (Mark all applicable boxes)										
X Statement of Actual Services Request for Predetermination/Pre	authorization									
X EPSDT / Title XIX		L			,					
2. Predetermination/Preauthorization Number		P	OLICYHOLI	DER/S	UBSCRIB	R INFORMAT	ION (For Insura	nce Company N	lamed in #3)	
		12	2. Policyholder	/Subsc	riber Name (l	ast, First, Middle	Initial, Suffix), A	ddress, City, Sta	te, Zip Code	
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		$\Box$ ,	GENUINO	) RO	Y					
3. Company/Plan Name, Address, City, State, Zip Code			3800 HEA							
METLIFE			WINSTON			27127				
PO BOX 981282							T			
EL PASO, TX 79998			3. Date of Birth	•	DD/CCYY)	14. Gender  M F	.	der/Subscriber II	D (SSN or ID#)	
		_	02/05/197				2307110	46		
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, I		_	6. Plan/Group I 310649	Numbe		7. Employer Nam ECOLAB	ie			
4. Dental? Medical? (If both, complete 5-11 for dental only	y.)	-				COLAB				
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		F	ATIENT INF					10 Bassa	ed For Future	
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscribe	ID (00N ID#)	18	8. Relationship Self		_	scriber in #12 Ab Dependent Child		Use Use	ea roi ruiure	
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscribe	er ID (SSN or ID#)	20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
9. Plan/Group Number 10. Patient's Relationship to Person named	in #5	GENUINO, MARIANO								
Self Spouse Dependen		3800 HEATHER LANE								
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip	Code	_	WINSTON			27127				
					•					
	21	21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assi								
			04/20/2002 XM F 805041162814							
RECORD OF SERVICES PROVIDED										
	8. Tooth 29. Pro		29a. Diag.	29b.		30. De	escription		31. Fee	
(MIN/DD/CCYY) Cavity System of Letter(s)	Surface Co		Pointer	Qty.						
1 11/28/2016	D867	0	PERIOD ORTHO TX INSTALLMENT						150.00	
3										
4										
5										
6										
			+ +							
9										
10										
33. Missing Teeth Information (Place an "X" on each missing tooth.)	34 Diagnosis	e Code	List Qualifier		( ICD-9 = 1	B; ICD-10 = AB )		31a. Other		
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 1				A	(100-3-1	C		Fee(s)		
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 1	—		` '	^		C		32. Total Fee	150.00	
35. Remarks	, , ,		· ·						100.00	
AUTHORIZATIONS		ANC	CILLARY CL	AIM/	TREATME	NT INFORMAT	TION			
36. I have been informed of the treatment plan and associated fees. I agree to be recharges for dental services and materials not paid by my dental benefit plan, unlike		38. P		_		office; 22=O/P Ho		losures (Y or N)		
law, or the treating dentist or dental practice has a contractual agreement with my	plan prohibiting all		(Use "Place of	of Service	ce Codes for Pi	ofessional Claims")				
or a portion of such charges. To the extent permitted by law, I consent to your us of my protected health information to carry out payment activities in connection v		40. Is	s Treatment for				ı	ppliance Placed	(MM/DD/CCYY)	
X SIGNATURE ON FILE 11/28/	2016		No (Skip			Complete 41-42)				
Patient/Guardian Signature Date		42. N	Months of Treat	tment	I — ' –	cement of Prosthe		f Prior Placemen	it (MM/DD/CCYY)	
37. I hereby authorize and direct payment of the dental benefits otherwise payable to the below named dentist or dental entity.	to me, directly	<u> </u>	8		No	Yes (Complete	44)			
		45. 1	Freatment Resu	-		☐ Auto o	ooidont [	Other engider	n+	
X SIGNATURE ON FILE 11/28/ Subscriber Signature Date	2016	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 denta	Lontity is not	_				ATMENT LOC	ATION INFO		ent State	
submitting claim on behalf of the patient or insured/subscriber.)	i entity is not	⊢							es that require	
48. Name, Address, City, State, Zip Code		53. I hereby certify that the procedures as indicated by date are in progress (for procedures that requ multiple visits) or have been completed.						es mai require		
Kenneth M. Sadler, DDS and Associates, PA										
201 Charlois Boulevard		X         Dr. Martin         Slominski         11/28/2016           Signed (Treating Dentist)         Date								
Winston-Salem, NC 27103		54. NPI 1790716421 55. License Number								
		56. Address, City, State, Zip Code 56a. Provider Specialty Code 1223X0400X								
49. NPI 50. License Number 51. SSN or TII			Charlois Blv		100					
1144309410 4151 56-2132960	6		ston-Salem, I	NC 27	103					
52. Phone Number (336) 331-3500 52a. Additional Provider ID		57. P	Phone Number (33	6) 33	1-3500	58.	Additional Provider ID 90	)3HC		

ADA American Dental Association® Dental Cla	im For	m								
HEADER INFORMATION										
1. Type of Transaction (Mark all applicable boxes)										
X Statement of Actual Services Request for Predetermination/Preauthor	rization									
X EPSDT / Title XIX										
2. Predetermination/Preauthorization Number		P	OLICYHOL	DER/S	UBSCRIB	ER INFORMA	TION (Fo	r Insurance	Company N	amed in #3)
		12	2. Policyholder	r/Subsc	riber Name (	Last, First, Middle	e Initial, Su	uffix), Addre	ess, City, Sta	te, Zip Code
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		٦,	MATHES	או כ	ארוי בי	2				
3. Company/Plan Name, Address, City, State, Zip Code			433 HOLI	,		)				
METLIFE			WINSTON			27104				
PO BOX 981282			************	<b>1</b> O/ (L	LLIVI, IVO	27104				
EL PASO, TX 79998		13	<ol><li>Date of Birth</li></ol>	n (MM/E	DD/CCYY)	14. Gender		olicyholder/s	Subscriber II	O (SSN or ID#)
		┙	12/04/195	52		X M U	F 238	769548		
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave by	olank.)	_	6. Plan/Group	Numbe	I	7. Employer Nar				
4. Dental? Medical? (If both, complete 5-11 for dental only.)		┸	305584		1	NOVANT HE	EALTH			
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		P.	ATIENT IN	FORM	ATION					
		18	_ '		_	scriber in #12 Al			19. Reserve	ed For Future
6. Date of Birth (MM/DD/CCYY)  7. Gender  8. Policyholder/Subscriber ID (\$	SSN or ID#)	Self Spouse X Dependent Child Other								
MF		20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
9. Plan/Group Number 10. Patient's Relationship to Person named in #5	7 044		MATHES							
Self Spouse Dependent	Other	_	433 HOLII			07404				
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code			WINSTON	N-SAL	LEM, NC	2/104				
		2.	21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (#						oount # (Assi	anod by Dontiet)
			12/07/2001 XM F 805043162813						•	gried by Deritist)
RECORD OF SERVICES PROVIDED		_	12/01/200			<u> </u>	10000	0-101020		
25 Area 26	n 29. Proc		non Dina	201						
24. Procedure Date (MM/DD/CCYY)   25. Tooth   27. Tooth Number(s)   28. Tooth   27. Tooth Number(s)   28. Tooth   27. Tooth   28. Tooth			29a. Diag. Pointer	29b. Qty.		30. E	Description			31. Fee
1 11/28/2016	D8670	)			PERIOD	ORTHO TX	INSTAL	LMENT		150.00
2										
3										
4										
5										
6										
7										
8										
9										
10										
33. Missing Teeth Information (Place an "X" on each missing tooth.)	34. Diagnosis	Code	List Qualifier		( ICD-9 =	B; ICD-10 = AB )	)	31:	a. Other Fee(s)	
	34a. Diagnosi		. ,	Α		c		—		
	(Primary diag	nosis	in " <b>A</b> ")	В		D		32.	. Total Fee	150.00
35. Remarks										
AUTHORITATIONS		A N I 4	011 I ABY 01			UT INFORMA	TION			
<b>AUTHORIZATIONS</b> 36. I have been informed of the treatment plan and associated fees. I agree to be responsi	ble for all					=office; 22=O/P Ho		39. Enclosu	res (Y or N)	
charges for dental services and materials not paid by my dental benefit plan, unless pro law, or the treating dentist or dental practice has a contractual agreement with my plan p	ohibited by	50.1		_		rofessional Claims'		SO. Ellologa		
or a portion of such charges. To the extent permitted by law, I consent to your use and	disclosure	40. Is	s Treatment fo	r Ortho	dontics?		41.	Date Appli	ance Placed	(MM/DD/CCYY)
of my protected health information to carry out payment activities in connection with this X SIGNATURE ON FILE 11/28/2016			No (Ski			(Complete 41-42	.	/12/2015		(
X SIGNATURE ON FILE 11/28/2018 Patient/Guardian Signature Date	<u> </u>	42. N	Months of Trea	tment		cement of Prosth				t (MM/DD/CCYY)
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me	directly		6		No	Yes (Complete	e 44)			,
to the below named dentist or dental entity.	, directly	45. T	reatment Res	ulting fr	om					
X SIGNATURE ON FILE 11/28/2016	6		Occupa	tional ill	ness/injury	Auto a	accident		Other accider	nt
Subscriber Signature Date		46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State							nt State	
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity	is not	TRE	ATING DEI	NTIST	AND TRE	ATMENT LO	CATION	INFORM	ATION	
submitting claim on behalf of the patient or insured/subscriber.)						as indicated by	date are in	progress (1	for procedure	es that require
48. Name, Address, City, State, Zip Code		n	nultiple visits)	or have	been comple	eted.				
Kenneth M. Sadler, DDS and Associates, PA		X Dr Deborah F Novak 11/28/2016								
201 Charlois Boulevard Winston-Salem, NC 27103		Signed (Treating Dentist)  Date								
		54. NPI 1457441420 55. License Number  56. Address City State Zin Code 56a. Provider 42000000000000000000000000000000000000								
			Address, City, S		ip Code	56   Sp	a. Provide pecialty Co	de 1223	X0400X	
49. NPI 50. License Number 51. SSN or TIN			Charlois Blv ston-Salem,		103					
1144309410 4151 56-2132966 52. Phone (336) 331 3500 52a. Additional			Oh a m a			1 50	8. Additiona	al		
S2. Phone Number (336) 331-3500 S2a. Additional Provider ID		57.F	none Number (33	36) 33	1-3500	58	. Additiona Provider	ID		

ADA American Dental Association® Dental Claim	Forr	n								
HEADER INFORMATION										
Type of Transaction (Mark all applicable boxes)										
X Statement of Actual Services Request for Predetermination/Preauthorization	ion									
X EPSDT / Title XIX		上								
2. Predetermination/Preauthorization Number		-				ER INFORMA		·		
		12	2. Policyholde	r/Subsc	riber Name (	Last, First, Midd	lle Initia	l, Suffix), Addr	ess, City, Sta	te, Zip Code
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		-  r	MATHES	ON, C	CHARLES	3				
Company/Plan Name, Address, City, State, Zip Code     METLIFE		4	433 HOLI	DAY	ST					
PO BOX 981282		\	WINSTON	N-SAL	LEM, NC	27104				
EL PASO, TX 79998		13	B. Date of Birtl	h (MM/F	DD/CCYY)	14. Gender	15	5 Policyholder	/Subscriber II	D (SSN or ID#)
			12/04/19	•	,	l	-	38769548		- (,
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank	(.)	-	6. Plan/Group		er 1	17. Employer Na		00700040		
4. Dental? Medical? (If both, complete 5-11 for dental only.)	,	-	305584			NOVANT H		ГН		
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		P/	ATIENT IN	FORM	ATION					
		18	3. Relationship	p to Poli	cyholder/Sub	oscriber in #12 A	bove			ed For Future
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN	or ID#)	Self Spouse X Dependent Child Other								
M F		20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
9. Plan/Group Number 10. Patient's Relationship to Person named in #5		MATHESON, PAUL T								
	her	433 HOLIDAY ST WINSTON-SALEM, NC 27104								
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code			WINSTON	N-SAL	EM, NC	27104				
		21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assigner							inned by Dentiet)	
			12/07/200		DD/CCYY)	22. Gender				gned by Dentist)
RECORD OF SERVICES PROVIDED			12/07/2001 X M J F 805044162812						012	
24 Procedure Date 25. Area 26. 27 Tooth Number(s) 28 Tooth	29. Proce	dure	29a. Diag.	29b.						
(MM/DD/CCYY) of Oral Tooth Cavity System or Letter(s) Surface	Code		Pointer	Qty.		30.	Descript	tion		31. Fee
1 11/28/2016	D8670				PERIOD	ORTHO TX	INST	TALLMENT		150.00
2										
3										
4										
5										
6										
7										
8										
10										
	Diagnosis (	-ode	List Qualifier		(ICD-9 =	B; ICD-10 = AB	)	3.	1a. Other	
	. Diagnosis			<u>Ш</u>	(100-0-	C	,		Fee(s)	
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 (Prin	mary diagn	osis i	in " <b>A</b> ")	В				32	2. Total Fee	150.00
35. Remarks										
AUTHORIZATIONS						NT INFORMA				
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for charges for dental services and materials not paid by my dental benefit plan, unless prohibition.	ited by	38. P		_		=office; 22=O/P F rofessional Claims		39. Enclosi	ures (Y or N)	
law, or the treating dentist or dental practice has a contractual agreement with my plan prohil or a portion of such charges. To the extent permitted by law, I consent to your use and discl	locure F	40 1-				Tolessional Claims	• )		L. Blacca	(MMA/DD/00)()()
of my protected health information to carry out payment activities in connection with this cla	im.	40. IS	Treatment fo			(Complete 41-42	2)			(MM/DD/CCYY)
X SIGNATURE ON FILE 11/28/2016 Patient/Guardian Signature Date	— ŀ	42 N	Months of Trea			cement of Prostl		8/12/2015		it (MM/DD/CCYY)
		72. IV	6	aunent	No [	Yes (Comple		Jake of F	nor r lacemen	it (WIWIDD/OOTT)
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, direct to the below named dentist or dental entity.		45. T	reatment Res	sulting fr	om		,			
X SIGNATURE ON FILE 11/28/2016			Occupa	itional ill	ness/injury	Auto	accide	nt 🗀	Other accider	nt
Subscriber Signature Date	— t	46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State							ent State	
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is n	ot	TRE	ATING DE	NTIST	AND TRE	ATMENT LO	CATIO	ON INFORM	IATION	
submitting claim on behalf of the patient or insured/subscriber.)						as indicated by	date ar	re in progress	(for procedure	es that require
48. Name, Address, City, State, Zip Code		multiple visits) or have been completed.								
Kenneth M. Sadler, DDS and Associates, PA		χ Dr Deborah F Novak 11/28/2016								
201 Charlois Boulevard Winston-Salem, NC 27103	ļ	Signed (Treating Dentist)         Date           54. NPI 1457441420         55. License Number								
	- H									
40 NDI			ddress, City,		ip Code	Š	pecialty	Code 122	3X0400X	
49. NPI			Charlois Blv ston-Salem,		103					
52. Phone (336) 334 3500   52a. Additional		57. P	hone (23		1-3500	5	8. Addit	tional		
Number (336) 33 I-3500 Provider ID		N	lumber (33	JU) JJ	1-0000		Prov	ider ID		

ADA American Dentai A	Association Dent	ai Ciaim	Form									
HEADER INFORMATION												
Type of Transaction (Mark all applicable by the state of the stat	boxes)											
X Statement of Actual Services	Request for Predeterminatio	n/Preauthorization	on									
X EPSDT / Title XIX			l									
2. Predetermination/Preauthorization Numb	ber			POLICYHOLI	DER/S	UBSCRIB	ER INFORMA	TION (For Ins	surance Company N	amed in #3)		
				12. Policyholder	/Subsc	riber Name (	Last, First, Middle	e Initial, Suffix)	, Address, City, Stat	te, Zip Code		
INSURANCE COMPANY/DENTAL E	BENEFIT PLAN INFORMAT	ION		MOORE, I	KFIT	Δ						
3. Company/Plan Name, Address, City, Stat	ate, Zip Code			309 SPRI								
METLIFE				WALNUT	_		052-9549					
PO BOX 981282												
EL PASO, TX 79998				13. Date of Birth	•	DD/CCYY)	14. Gender	1	holder/Subscriber II	O (SSN or ID#)		
				08/01/197			M X		4504			
OTHER COVERAGE (Mark applicable b	·		.)	16. Plan/Group I	Numbe		17. Employer Nar					
4. Dental? Medical?	(If both, complete 5-11 for denta	al only.)		305584			NOVANT HE	EALIH				
5. Name of Policyholder/Subscriber in #4 (L	Last, First, Middle Initial, Suffix)		ŀ	PATIENT INF					10 Bassa	ad Can Cutuma		
6. Date of Birth (MM/DD/CCYY) 7. Ge	onder on the second	"		18. Relationship		. –	oscriber in #12 Al		Use Use	ed For Future		
	ender 8. Policyholder/Sub	scriber ID (SSN o	or ID#)	Self Spouse X Dependent Child Other  20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
	Patient's Relationship to Person na	med in #5										
I		endent Oth	ner	MOORE, BETHANY G 309 SPRINGDALE RD								
11. Other Insurance Company/Dental Bener	efit Plan Name, Address, City, State	e. Zip Code		WALNUT	_		052-9549					
, , , , , , , , , , , , , , , , , , , ,	, , , , , , , , , ,	,,										
	ı	21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assign						gned by Dentist)				
				05/28/200	3		M X	805055	5162811			
RECORD OF SERVICES PROVIDED	D		•									
24. Procedure Date 25. Area 26. of Oral Toot	oth 27. Tooth Number(s)	28. Tooth	29. Procedu		29b.		30. Г	escription		31. Fee		
(MIM/DD/CCYY) Cavity Syste		Surface	Code	Pointer	Qty.							
1 11/28/2016			D8670			PERIOD	ORTHO TX	INSTALLM	IENT	150.00		
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4												
5												
6												
8												
9												
10												
33. Missing Teeth Information (Place an "X"	" on each missing tooth )	34 0	Diagnosis Co.	de List Qualifier		(ICD-9 =	B; ICD-10 = AB )	1	31a. Other			
1 2 3 4 5 6 7 8			Diagnosis C			(100-0-	C	<u>'</u>	Fee(s)			
32 31 30 29 28 27 26 25			nary diagnos	-i- :- «A»\	^				32. Total Fee	150.00		
35. Remarks				,	<u> </u>				_	100.00		
AUTHORIZATIONS			A	NCILLARY CL	AIM/	TREATME	NT INFORMA	TION				
36. I have been informed of the treatment pla charges for dental services and materials				3. Place of Treatm			=office; 22=O/P Ho	· · · · · · · · · · · · · · · · · · ·	Enclosures (Y or N)			
law, or the treating dentist or dental practi	tice has a contractual agreement wi	th my plan prohib	oiting all	(Use "Place of	of Servi	ce Codes for P	rofessional Claims'	"				
or a portion of such charges. To the exter of my protected health information to car				). Is Treatment for				- 1	te Appliance Placed	(MM/DD/CCYY)		
X SIGNATURE ON FILE		/28/2016	_	No (Skip			(Complete 41-42	0, .0,	2015			
Patient/Guardian Signature	Dat	е	42	2. Months of Treat	tment	I — ' -	cement of Prosth		te of Prior Placemen	t (MM/DD/CCYY)		
37. I hereby authorize and direct payment of		yable to me, dire		9		No	Yes (Complete	e 44)				
to the below named dentist or dental en	•		45	. Treatment Resu	-		Ato					
X SIGNATURE ON FILE	<del>-</del>	/28/2016				ness/injury	Auto	accident	Other accider			
	Subscriber Signature Date  LLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not					46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State  TREATING DENTIST AND TREATMENT LOCATION INFORMATION						
submitting claim on behalf of the patient or		ueritai eritity is rit							gress (for procedure	es that require		
48. Name, Address, City, State, Zip Code	Name, Address, City, State, Zip Code					been compl		aute are in pro	gress (for procedure	23 that require		
1	enneth M. Sadler, DDS and Associates, PA				Sla	mineki			11/28/2016			
201 Charlois Boulevard	1 Charlois Boulevard				X Dr. Martin Slominski 11/28/2016 Signed (Treating Dentist) Date							
Winston-Salem, NC 27103	Vinston-Salem, NC 2/103				54. NPI 1790716421 55. License Number							
				56. Address, City, State, Zip Code Specialty Code 1223X0400X								
1	nse Number 51. SSN			01 Charlois Blvd		400	15.	,				
1144309410 4151	56-213	2966		/inston-Salem, I	NC 27	103						
<sup>52. Phone</sup> Number (336) 331-3500	52a. Additional Provider ID		57	7. Phone Number (33	6) 33	1-3500	58	. Additional Provider ID	903HC			

ADA American Dental Association Dental	Claim Fol	rm								
HEADER INFORMATION										
Type of Transaction (Mark all applicable boxes)										
X Statement of Actual Services Request for Predetermination/Pre	eauthorization									
X EPSDT / Title XIX										
Predetermination/Preauthorization Number		Р	POLICYHOLI	DER/S	UBSCRIB	ER INFORMA	TION (For Ins	surance Company N	amed in #3)	
		1:	12. Policyholder	/Subsc	riber Name (	Last, First, Middl	e Initial, Suffix)	), Address, City, Stat	te, Zip Code	
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION			SZVETITZ	7 10	SEDH I					
3. Company/Plan Name, Address, City, State, Zip Code			1631 DUP							
METLIFE		- 1		_	-	27103-480	3			
PO BOX 981282		L	***************************************	. 0, 1		27 100 100				
EL PASO, TX 79998		1:	<ol><li>Date of Birth</li></ol>	(MM/E	DD/CCYY)	14. Gender	15. Policy	holder/Subscriber II	O (SSN or ID#)	
			08/06/197	7		X M	<sup>F</sup> 155703	3580		
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none,	eave blank.)	1	16. Plan/Group I	Numbe	er 1	7. Employer Na	me			
4. Dental? Medical? (If both, complete 5-11 for dental onl	y.)		120731		F	EDERAL D	DENTAL			
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		Р	PATIENT INF	ORM	ATION					
		1	18. Relationship	to Poli	icyholder/Sub	scriber in #12 A	bove	19. Reserve	ed For Future	
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscribe	er ID (SSN or ID#)	Self Spouse X Dependent Child Other								
MF		20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
9. Plan/Group Number 10. Patient's Relationship to Person named		SZVETITZ, ANDREW								
Self Spouse Depender	t Other		1631 DUPONT RD							
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip	Code		WINSTON SALEM, NC 27103-4803							
		⊢								
		2	21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assign						gned by Dentist)	
			05/13/2002 X M F 805017162810							
RECORD OF SERVICES PROVIDED										
(MM/DD/CCVV) of Oral Tooth or Letter(c)		cedure de	29a. Diag. Pointer	29b. Qty.		30. [	Description		31. Fee	
Cavity System			1 onte	Gty.	DEDIOD	ODTUO TV	INICTALLA	4ENT	140.00	
1 11/28/2016	D867	0			PERIOD	ORTHO TX	INSTALLIV	IENI	140.63	
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5			1							
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10	1							lat aii		
33. Missing Teeth Information (Place an "X" on each missing tooth.)			e List Qualifier		( ICD-9 =	B; ICD-10 = AB	)	31a. Other Fee(s)		
	6 34a. Diagno		. ,	Α		c		- 32. Total Fee		
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 1	7 (Primary dia	ignosis	s in "A")	В		D		32. Total Fee	140.63	
35. Remarks										
AUTHORIZATIONS		LANG	CILL ABV CI	A IBA/	TDEATME	NT INFORMA	TION			
36. I have been informed of the treatment plan and associated fees. I agree to be re	sponsible for all	+	Place of Treatm			=office; 22=O/P H		Enclosures (Y or N)		
charges for dental services and materials not paid by my dental benefit plan, unl	ess prohibited by	1				rofessional Claims				
law, or the treating dentist or dental practice has a contractual agreement with my or a portion of such charges. To the extent permitted by law, I consent to your us	e and disclosure	-	Is Treatment for	r Ortho	dontics?		41 Dat	te Appliance Placed	(MM/DD/CCYY)	
of my protected health information to carry out payment activities in connection v  X SIGNATURE ON FILE 11/28/		-0.1	No (Skip			(Complete 41-42	.	/2015	(WINVIDE/COTT)	
X SIGNATURE ON FILE 11/28/ Patient/Guardian Signature Date	2010	42 1	Months of Treat			cement of Prosth	0, = .,	te of Prior Placemen	t (MM/DD/CCYY)	
			6		No	Yes (Complet			(	
<ol> <li>I hereby authorize and direct payment of the dental benefits otherwise payable to the below named dentist or dental entity.</li> </ol>	to me, directly	45.	Treatment Resu	ultina fr		100 (00p	•,			
x SIGNATURE ON FILE 11/28/	/2016			-	Iness/injury	Auto	accident	Other accider	nt	
X SIGNATURE ON FILE 11/28/ Subscriber Signature Date	2010	46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State							nt State	
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or denta	l entity is not	+-				ATMENT LO	CATION INF		THE OTHER	
submitting claim on behalf of the patient or insured/subscriber.)	a chary is not	_						gress (for procedure	es that require	
48. Name, Address, City, State, Zip Code			multiple visits) o				210 111 010	g. III (10) procedure	roquiro	
Kenneth M. Sadler, DDS and Associates, PA		V. Dr. Martin Claminalii 44/00/0043								
201 Charlois Boulevard		X Dr. Martin Slominski 11/28/2016 Signed (Treating Dentist) Date								
Winston-Salem, NC 27103		54. NPI 1790716421 55. License Number								
		56. Address, City, State, Zip Code Specialty Code 1223X0400X								
49. NPI 50. License Number 51. SSN or TII	N	201 Charlois Blvd								
1144309410 4151 56-213296			nston-Salem, N		103					
52. Phone Number (336) 331-3500   52a. Additional Provider ID		57. F	Phone (33	6) 33	1-3500	58	B. Additional Provider ID	903HC		
Number (336) 331-3300 Provider ID		<u> </u>	Number (33	-,			FIOVIGET ID			

ADA American Dental Association Dental Claim Fo	orm								
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	POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)								
	12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	CORRING SHENITA								
3. Company/Plan Name, Address, City, State, Zip Code	COBBINS, SHENITA PO BOX 4266								
METLIFE	WINSTON SALEM, NC 27115								
PO BOX 981282	WING FOR GALLIN, NO 27 110								
EL PASO, TX 79998	13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscriber ID (SSN or ID#)								
	01/30/1967 □ <sup>M</sup> X <sup>F</sup>   237196662								
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)	16. Plan/Group Number 17. Employer Name								
4. Dental? Medical? (If both, complete 5-11 for dental only.)	305584 NOVANT HEALTH								
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)	PATIENT INFORMATION								
	18. Relationship to Policyholder/Subscriber in #12 Above Use								
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN or ID#	Self Spouse X Dependent Child Other								
MF	20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
9. Plan/Group Number 10. Patient's Relationship to Person named in #5	COBBINS, JORDEN M								
Self Spouse Dependent Other	PO BOX 4266								
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	WINSTON SALEM, NC 27115								
	04 0 4 65 4 444 50 20 20 4 4 4 5 4 5 4 5 4 5 4 5 4 5 4 5 4 5 4								
	21. Date of Birth (MM/DD/CCYY)   22. Gender   23. Patient ID/Account # (Assigned by Dentis								
	12/17/2002 X M F 800516162809								
RECORD OF SERVICES PROVIDED									
24. Procedure Date of Oral Tooth 27. Tooth Number(s) 28. Tooth 29. Furface 29.	Procedure 29a. Diag. 29b. Code Pointer Qty. 30. Description 31. Fee								
1 11/28/2016 D86									
2	TO TENOD ON THO TAINOTALLIMENT 130.0								
3									
4									
5									
6									
7									
8									
9									
10									
33. Missing Teeth Information (Place an "X" on each missing tooth.) 34. Diagno	osis Code List Qualifier (ICD-9 = B; ICD-10 = AB) 31a. Other								
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 34a. Diagr	nosis Code(s) A C								
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 (Primary d	diagnosis in "A") B D 32. Total Fee 150.0								
35. Remarks	<u> </u>								
AUTHORIZATIONS	ANCILLARY CLAIM/TREATMENT INFORMATION								
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	38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) 39. Enclosures (Y or N)								
law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting a or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure	all (Use Place of Service Codes for Professional Claims )								
of my protected health information to carry out payment activities in connection with this claim.	40. Is Treatment for Orthodontics?								
X SIGNATURE ON FILE 11/28/2016	No (Skip 41-42) X Yes (Complete 41-42) 3/25/2015								
Patient/Guardian Signature Date	42. Months of Treatment 43. Replacement of Prosthesis 44. Date of Prior Placement (MM/DD/CCY								
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly	9 No Yes (Complete 44)								
to the below named dentist or dental entity.	45. Treatment Resulting from								
X SIGNATURE ON FILE 11/28/2016	Occupational illness/injury Auto accident Other accident								
Subscriber Signature Date	46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State								
<b>BILLING DENTIST OR DENTAL ENTITY</b> (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)	TREATING DENTIST AND TREATMENT LOCATION INFORMATION								
48. Name, Address, City, State, Zip Code	53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.								
Kenneth M. Sadler, DDS and Associates, PA									
201 Charlois Boulevard	X Dr Deborah F Novak 11/28/2016 Signed (Treating Dentist) Date								
Winston-Salem, NC 27103	54. NPI 1457441420 55. License Number								
	56. Address, City, State, Zip Code Specialty Code 1223X0400X								
49. NPI 50. License Number 51. SSN or TIN	201 Charlois Blvd								
1144309410 4151 56-2132966	Winston-Salem, NC 27103								
52. Phone Number (336) 331-3500   52a. Additional Provider ID	57. Phone Number (336) 331-3500   58. Additional Provider ID								
I MUNDEL \ /	Trumber 1 / / Flovider ID								

ADA American Dental Association® Dental Claim Fo	<u>rm</u>							
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	POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)							
	12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code							
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	POE, LISA I							
Company/Plan Name, Address, City, State, Zip Code     METLIFE	6390 BISHOP RIDGE LN							
PO BOX 981282	RURAL HALL, NC 27045							
EL PASO, TX 79998	13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscriber ID (SSN or ID#)							
	07/05/1966 MXF 287586163							
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)	16. Plan/Group Number 17. Employer Name							
4. Dental? Medical? (If both, complete 5-11 for dental only.)	0120731 FEDERAL DENTAL							
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)	PATIENT INFORMATION							
	18. Relationship to Policyholder/Subscriber in #12 Above 19. Reserved For Future							
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN or ID#	Self Spouse X Dependent Child Other							
M F	20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code							
9. Plan/Group Number 10. Patient's Relationship to Person named in #5	POE, ADAM M							
Self Spouse Dependent Other	6390 BISHOP RIDGE LN							
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	RURAL HALL, NC 27045							
	24 Data of Dieth (MM/DD/COVA) 22 Conder 22 Dation (DA count M/Accional Inc. Dantier)							
	21. Date of Birth (MM/DD/CCYY)							
DECORD OF CERVICES PROVIDED	VI/10/2001							
RECORD OF SERVICES PROVIDED  24. Procedure Date   25. Area   26.   27. Tooth Number(s)   28. Tooth   29. P	rocedure 29a, Diag. 29b.							
	Code Pointer Qty. 30. Description 31. Fee							
1 11/28/2016 D86	70 PERIOD ORTHO TX INSTALLMENT 140.00							
2								
3								
4								
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6								
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8								
9								
33. Missing Teeth Information (Place an "X" on each missing tooth.) 34. Diagno	sis Code List Qualifier (ICD-9 = B; ICD-10 = AB) 31a. Other							
	osis Code(s)  A  C							
	iagnosis in "A") B D 32. Total Fee 140.00							
35. Remarks	<u> </u>							
AUTHORIZATIONS	ANCILLARY CLAIM/TREATMENT INFORMATION							
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	38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) 39. Enclosures (Y or N)							
law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting a or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure	(Use "Place of Service Codes for Professional Claims")							
of my protected health information to carry out payment activities in connection with this claim.	41. Date Appliance Placed (MM/DD/Co							
X SIGNATURE ON FILE 11/28/2016	No (Skip 41-42) X Yes (Complete 41-42) 6/10/2015							
Patient/Guardian Signature Date	42. Months of Treatment 43. Replacement of Prosthesis 44. Date of Prior Placement (MM/DD/CCYY  No Yes (Complete 44)							
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.	45. Treatment Resulting from							
·	Occupational illness/injury Auto accident Other accident							
X SIGNATURE ON FILE 11/28/2016 Subscriber Signature Date	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	TREATING DENTIST AND TREATMENT LOCATION INFORMATION							
submitting claim on behalf of the patient or insured/subscriber.)	53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require							
48. Name, Address, City, State, Zip Code	multiple visits) or have been completed.							
Kenneth M. Sadler, DDS and Associates, PA	x Dr Deborah F Novak 11/28/2016							
201 Charlois Boulevard Winston-Salem, NC 27103	Signed (Treating Dentist)  Date							
Thistory during the Er 100	54. NPI 1457441420 55. License Number							
	56. Address, City, State, Zip Code 56a. Provider Specialty Code 1223X0400X							
49. NPI 50. License Number 51. SSN or TIN	201 Charlois Blvd Winston-Salem, NC 27103							
1144309410 4151 56-2132966 52. Phone (236) 331 3500 52a. Additional	57 Dhana							
Number (336) 331-3500 Sza. Additional Provider ID	Number (336) 331-3500   St. Additional Provider ID							

ADA American Den	tai As	SOCI	ation	Denta	ai Ciai	m For	m								
HEADER INFORMATION															
Type of Transaction (Mark all app	licable bo	xes)													
X Statement of Actual Services		Requ	est for Predet	terminatio	n/Preauthoriz	zation									
X EPSDT / Title XIX															
2. Predetermination/Preauthorization Number						Р	POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)								
					12	12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code									
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION						╝,	GRIFFITH	I TR	ACI						
3. Company/Plan Name, Address, C	city, State,	Zip Cod	е					1040 WO	,						
METLIFE								KING, NC		_					
PO BOX 981282								14140, 140 27021							
EL PASO, TX 79998							13	13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscriber ID (SSN or ID#)							
								01/14/1983							
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)								16. Plan/Group Number 17. Employer Name							
4. Dental? Medical?		(If both,	complete 5-1	1 for denta	al only.)		ᆚ	305584 NOVANT HEALTH							
5. Name of Policyholder/Subscriber	in #4 (La:	st, First, I	Middle Initial,	Suffix)			P.	ATIENT IN	FORM	ATION					
	,						18	18. Relationship to Policyholder/Subscriber in #12 Above Use							
Date of Birth (MM/DD/CCYY)	7. Geno		8. Policyho	older/Subs	scriber ID (SS	SN or ID#)	$\perp$	Self	Sp	pouse X	Dependent Ch	ild	Other		
	Шм	F					20	D. Name (Last,	, First, N	Middle Initial,	Suffix), Address	s, City	, State, Zip Co	ode	
9. Plan/Group Number			ationship to F					Griffith, Lo							
	Se		Spouse	ш .		Other		1040 Woo							
11. Other Insurance Company/Dent	al Benefit	Plan Nar	ne, Address,	City, State	e, Zip Code			King, NC 2	27021	1					
								1. Date of Birth		DD/CCYY)	22. Gender			*	igned by Dentist)
								08/08/200	)2		XM		80502716	2807	
RECORD OF SERVICES PRO								1 1		I					I
24. Procedure Date of Or	al Tooth	27	<ol><li>Tooth Number or Letter(s)</li></ol>	er(s)	28. Tooth Surface	29. Prod Cod		29a. Diag. Pointer	29b. Qty.		30. Description				31. Fee
1 11/28/2016	y System		(-)			D8670				PERIOD ORTHO TX INSTALLMENT					150.00
2										LINIOL	OKITIO 17	· IIVC	TALLIVILI	11	130.00
3															
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6						+									
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8															
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1	an "Y" or	n each m	issing tooth \		2	4 Diagnosis	Codo	List Qualifier		(100.9 =	P: ICD 10 - AB	١		31a. Other	
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 34a. Diagnosis								Fee(s)							
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 (Primary diagr								22 Total Fool						150.00	
35. Remarks						,	,		В						130.00
AUTHORIZATIONS							ANG	CILLARY CI	LAIM/	TREATME	NT INFORMA	ATIO	N		
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all						38. F	38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) 39. Enclosures (Y or N)								
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							(Use "Place	of Service	ce Codes for F	rofessional Claim	s")				
or a portion of such charges. To the extent permitted by law Leonsont to your use and disclosure						40. Is	40. Is Treatment for Orthodontics?  41. Date Appliance Placed (MM/DD/CCYY)								
X SIGNATURE ON FILE 11/28/2016						No (Skip 41-42) X Yes (Complete 41-42) 6/11/2015									
Patient/Guardian Signature Date						42. N	42. Months of Treatment 43. Replacement of Prosthesis 44. Date of Prior Placement (MM/DD/CCYY)							nt (MM/DD/CCYY)	
37. I hereby authorize and direct pa	vment of t	he denta	l benefits oth	erwise pav	vable to me.	directly	6 No Yes (Complete 44)								
I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.						45. T	45. Treatment Resulting from								
X SIGNATURE ON FILE 11/28/2016					Occupational illness/injury Auto accident Other accident										
Subscriber Signature Date						46. E	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				TRE	TREATING DENTIST AND TREATMENT LOCATION INFORMATION										
submitting claim on behalf of the patient or insured/subscriber.)					53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.										
48. Name, Address, City, State, Zip Code					<sup>n</sup>	nuitiple visits)	or nave	e peen compl	etea.						
Kenneth M. Sadler, DDS and Associates, PA					X	Dr. Martin	Slo	minski			1	1/28/2016			
201 Charlois Boulevard Winston-Salem, NC 27103						Signed (Treating Dentist) Date									
vviiistori-paterii, NC 27 105					_	<sup>NPI</sup> 17907					ense Number				
I –					56. A	56. Address, City, State, Zip Code Specialty Code 1223X0400X									
	0. License	Number	I	51. SSN 0			201 Charlois Blvd Winston-Salem, NC 27103								
	151		I	56-2132	2966				NC 27	103		0.4	dial a m - 1		
<sup>52. Phone</sup> Number (336) 331-3500			52a. Addition Provide	nal er ID			57. F	Phone Number (33	36) 33	1-3500	5	ಕ. Add <u>P</u> ro	ditional ovider ID 90	3HC	

ADA American Dental Association® Dental Claim Form	<u>n</u>							
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	POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)							
	12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code							
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	MAYER, WILLIAM FRANKLIN							
3. Company/Plan Name, Address, City, State, Zip Code	1270 CRESCENT MEADOW DR							
UNITED CONCORDIA P O BOX 69421	CLEMMONS, NC 27012							
HARRISBURG, PA 17106	13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscriber ID (SSN or ID#)							
17.444.0554.65,174.17.105								
OTHER COVERAGE (Made and Saddle house of assemble from 5 44 Manage Jasus blank)								
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)      Dental?    Medical?    (If both, complete 5-11 for dental only.)	16. Plan/Group Number 17. Employer Name 254758001 SHEETZ							
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)								
5. Name of Folloyfolder outsorber 11774 (East, Filst, Middle Illitati, Sality)	PATIENT INFORMATION  18. Relationship to Policyholder/Subscriber in #12 Above  19. Reserved For Future							
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN or ID#)	Self   Spouse   X Dependent Child   Other   Use							
M F	20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code							
9. Plan/Group Number 10. Patient's Relationship to Person named in #5	MAYER, BRADLEY							
Self Spouse Dependent Other	1270 CRESCENT MEADOW DR							
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	CLEMMONS, NC 27012							
	21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assigned by Dentist)							
	02/18/2002 XM F 805161162806							
RECORD OF SERVICES PROVIDED								
24. Procedure Date of Oral Tooth Number(s) 28. Tooth 29. Procedure Date of Oral Tooth Tooth Number(s) 28. Tooth 29. Procedure Date of Oral Tooth Number(s) 28. Tooth 29. Procedure Date of Oral Tooth Number(s) 28. Tooth Number(s) 28. Tooth Number(s) 29. Procedure Date of Oral Tooth Number(s) 28. Tooth Number(s) 29. Procedure Date of Oral Tooth Number(s) 28. Tooth Number(s) 29. Procedure Date of Oral Tooth Number(s) 29. Procedure Date of Oral Tooth Number(s) 28. Tooth Number(s) 29. Procedure Date of Oral Tooth Number(s) 29. Procedure Date								
(MIM/DD/CCYY) Cavity System or Letter(s) Surface Code	Pointer Qty.							
1 11/28/2016 D8670	PERIOD ORTHO TX INSTALLMENT 128.00							
3								
5								
6								
18								
9								
10								
33. Missing Teeth Information (Place an "X" on each missing tooth.) 34. Diagnosis	Code List Qualifier (ICD-9 = B; ICD-10 = AB) 31a. Other							
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 34a. Diagnosis	Fee(s)							
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 (Primary diagr								
35. Remarks	7 5 120.00							
AUTHORIZATIONS	ANCILLARY CLAIM/TREATMENT INFORMATION							
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	38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) 39. Enclosures (Y or N)							
law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all	(Use "Place of Service Codes for Professional Claims")							
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.	40. Is Treatment for Orthodontics?  41. Date Appliance Placed (MM/DD/CCYY							
X SIGNATURE ON FILE 11/28/2016	No (Skip 41-42) X Yes (Complete 41-42) 9/22/2016							
Patient/Guardian Signature Date	42. Months of Treatment 43. Replacement of Prosthesis 44. Date of Prior Placement (MM/DD/CCY							
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly	10 No Yes (Complete 44)							
to the below named dentist or dental entity.	45. Treatment Resulting from							
X SIGNATURE ON FILE 11/28/2016	Occupational illness/injury Auto accident Other accident							
Subscriber Signature Date	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.)	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.							
48. Name, Address, City, State, Zip Code								
Kenneth M. Sadler, DDS and Associates, PA 201 Charlois Boulevard	X Dr Deborah F Novak 11/28/2016							
Winston-Salem NC 27103	Signed (Treating Dentist)  54. NPI 1457441420  55. License Number							
	1407441420							
49. NPI 50. License Number 51. SSN or TIN	56. Address, City, State, Zip Code Specialty Code 1223X0400X							
	Winston-Salem, NC 27103							
52. Phone (226) 224 2500   52a. Additional	57. Phone Number (336) 331-3500   58. Additional Provider ID							
Number (336) 331-3300 Provider ID	Number (336) 331-3300 Provider ID							

ADA American Dental Association® Dental Cla	im For	m								
HEADER INFORMATION										
1. Type of Transaction (Mark all applicable boxes)										
X Statement of Actual Services Request for Predetermination/Preauthor	rization									
X EPSDT / Title XIX										
2. Predetermination/Preauthorization Number	P	POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)								
	12	12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	⅃ ,	FERRIS, JAMES								
3. Company/Plan Name, Address, City, State, Zip Code		1360 BET			RCH RD					
UNITED HEALTHCARE		MADISON, NC 27025								
PO BOX 30567 SALT LAKE CITY, UT 84130		13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscriber ID (SSN or ID#)								
SALT LAKE 0111, 01 04130			•	DD/CCYY)	14. Gender			D (SSN or ID#)		
		_	02/11/1901							
4. Dental? Medical? (If both, complete 5-11 for dental only.)	_	16. Plan/Group Number 17. Employer Name EVOQUA WATER TECHNOLOGIES LLC								
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)	_									
o. Name of Folloyifolder/odusoffiser if #4 (East, Filst, Middle Hittar, Gallix)		$\vdash$	PATIENT INFORMATION  18. Relationship to Policyholder/Subscriber in #12 Above  19. Reserved For Future							
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (\$	SSN or ID#)	┨'`	Self			Dependent Child		Use		
M F	3011 01 12117	20	0. Name (Last	<u> </u>		Suffix), Address,		L Code		
9. Plan/Group Number 10. Patient's Relationship to Person named in #5		-	FERRIS, I			,				
Self Spouse Dependent	Other		1360 BET			CH RD				
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code		7	MADISON	I, NC	27025					
		L								
		- 1	1. Date of Birth	-	DD/CCYY)	22. Gender	1	,	igned by Dentist)	
			09/04/200	)2		M X F	8051091	62805		
RECORD OF SERVICES PROVIDED										
24. Procedure Date of Oral Tooth (MM/DD/CCYY) 25. Area of Oral Tooth or Letter(s) 28. Tootf Oral Tooth or Letter(s) Surface			29a. Diag. Pointer	29b. Qty.		30. Description			31. Fee	
1   11/28/2016	D8670	)			PERIOD	DD ORTHO TX INSTALLMENT 1				
2		•			1 211102	011110 1711	TTO 17 LELIVIE		199.58	
3										
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7										
8										
9										
10										
33. Missing Teeth Information (Place an "X" on each missing tooth.)	34. Diagnosis	Code	List Qualifier		( ICD-9 = B; ICD-10 = AB ) 31a. Other Fee(s)					
	34a. Diagnosi		Code(s) A C							
	(Primary diag	nosis i	in " <b>A</b> ")	В		D		32. Total Fee	199.58	
35. Remarks										
AUTHORIZATIONS		ANC	CILL ABV CI	AIM/	TDEATME	NT INCOPMAT	ION			
36. I have been informed of the treatment plan and associated fees. I agree to be responsil		ANCILLARY CLAIM/TREATMENT INFORMATION  38. Place of Treatment 1 (e.g. 11=office; 22=O/P Hospital) 39. Enclosures (Y or N)								
charges for dental services and materials not paid by my dental benefit plan, unless pro- law, or the treating dentist or dental practice has a contractual agreement with my plan p	ohibited by		(Use "Place of Service Codes for Professional Claims")							
or a portion of such charges. To the extent permitted by law, I consent to your use and of my protected health information to carry out payment activities in connection with this	40. Is	40. Is Treatment for Orthodontics?  41. Date Appliance Placed (MM/DD/CCYY)								
X SIGNATURE ON FILE 11/28/2016		No (Skip 41-42) X Yes (Complete 41-42) 4/15/2016								
Patient/Guardian Signature Date	42. Months of Treatment 43. Replacement of Prosthesis 44. Date of Prior Placement (MM/DD/CCYY)									
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me	, directly	16 No Yes (Complete 44)								
to the below named dentist or dental entity.	45. Treatment Resulting from									
X SIGNATURE ON FILE 11/28/2016	Occupational illness/injury Auto accident Other accident									
Subscriber Signature Date	46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State									
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity submitting claim on behalf of the patient or insured/subscriber.)		TREATING DENTIST AND TREATMENT LOCATION INFORMATION								
48. Name, Address, City, State, Zip Code		53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.								
Kenneth M. Sadler, DDS and Associates, PA										
201 Charlois Boulevard	X_	X Dr. Martin Slominski 11/28/2016 Signed (Treating Dentist) Date								
Winston-Salem, NC 27103	54. N	54. NPI 1790716421 55. License Number								
			Address, City, S			568	a. Provider	223X0400X		
49. NPI 50. License Number 51. SSN or TIN		56. Address, City, State, Zip Code Specialty Code 1223X0400X  201 Charlois Blvd								
1144309410 4151 56-2132966			ston-Salem,	NC 27	103					
52. Phone Number (336) 331-3500 S2a. Additional Provider ID		57. P	Phone Number (33	36) 33	1-3500	58.	Additional 90 Provider ID	03HC		

ADA American Dental Association® Dental Claim F	<u>orm</u>								
HEADER INFORMATION									
Type of Transaction (Mark all applicable boxes)									
X Statement of Actual Services Request for Predetermination/Preauthorization									
X EPSDT / Title XIX									
2. Predetermination/Preauthorization Number		POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)							
	12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Co	de							
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	BARNEY, REGINA R	BARNEY, REGINA R							
Company/Plan Name, Address, City, State, Zip Code     UNITED HEALTHCARE	2185 MILLING RD								
PO BOX 30567	MOCKSVILLE, NC 27028-7332								
SALT LAKE CITY, UT 84130	13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscriber ID (SSN or ID#)								
	01/02/1964 MX 928486981	,							
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)	16. Plan/Group Number 17. Employer Name								
4. Dental? Medical? (If both, complete 5-11 for dental only.)	200344 WOMBLE CARLYLE SANDRIDGE & RICE	Ξ							
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)	PATIENT INFORMATION								
	18. Relationship to Policyholder/Subscriber in #12 Above 19. Reserved For Fu	ture							
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN or ID	#) Self Spouse X Dependent Child Other Use								
MF	20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
9. Plan/Group Number 10. Patient's Relationship to Person named in #5	BARNEY, WILLIAM P								
Self Spouse Dependent Other	2185 MILLING RD								
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	MOCKSVILLE, NC 27028-7332								
	21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assigned by D	)ontiet)							
	04/23/2001 X M F 805067162804	Jenusi)							
RECORD OF SERVICES PROVIDED	0 1/20/2001								
24 Procedure Date 25. Area 26. 27 Tooth Number(s) 28 Tooth 29	Procedure 29a. Diag. 29b.								
(MM/DD/CCYY) of Oral Cavity System or Letter(s) Surface	Code Pointer Qty. 30. Description 31. F	-ee							
1 11/28/2016 D8	670 PERIOD ORTHO TX INSTALLMENT 1	52.16							
2									
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7									
8									
10									
	osis Code List Qualifier (ICD-9 = B; ICD-10 = AB) 31a. Other								
	nosis Code(s) A C								
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 (Primary		52.16							
35. Remarks		020							
AUTHORIZATIONS	ANCILLARY CLAIM/TREATMENT INFORMATION								
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 or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure	(Use "Place of Service Codes for Professional Claims")								
of my protected health information to carry out payment activities in connection with this claim.	40. Is Treatment for Orthodontics?  41. Date Appliance Placed (MM/DD/C								
X SIGNATURE ON FILE 11/28/2016	No (Skip 41-42) X Yes (Complete 41-42) 10/29/2015								
Patient/Guardian Signature Date	42. Months of Treatment 43. Replacement of Prosthesis 44. Date of Prior Placement (MM/DD/CCY) No Yes (Complete 44)								
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.	45. Treatment Resulting from								
·	Occupational illness/injury Auto accident Other accident								
X SIGNATURE ON FILE 11/28/2016 Subscriber Signature Date	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	TREATING DENTIST AND TREATMENT LOCATION INFORMATION								
submitting claim on behalf of the patient or insured/subscriber.)	53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require								
48. Name, Address, City, State, Zip Code	multiple visits) or have been completed.								
Kenneth M. Sadler, DDS and Associates, PA	x Dr Deborah F Novak 11/28/2016	x Dr Deborah F Novak 11/28/2016							
201 Charlois Boulevard Winston-Salem, NC 27103	Signed (Treating Dentist)  Date								
The sale of the sa	54. NPI 1457441420 55. License Number								
	56. Address, City, State, Zip Code 56a. Provider Specialty Code 1223X0400X								
49. NPI 50. License Number 51. SSN or TIN	201 Charlois Blvd Winston-Salem, NC 27103								
1144309410   4151   56-2132966 52. Phone (336) 231 3500   52a. Additional	F7 Dhana								
Sz. Phone Number (336) 331-3500 Sza. Additional Provider ID	Number (336) 331-3500   St. Additional Provider ID								