



**Dental
Benefit
Providers**

Clinical Information Request Form

To be used with the HIPAA approved fax template

Deliver to: TIMOTHY, TON **Fax number:** 775-823-9427
Phone number: 775-823-9419 **Date:** 07/20/2025

We have received a claim request for the following member:

Patient Name: CARLA, KIRK
Patient DOB: 07/03/1965

Service or line item:

Physician name: TIMOTHY, TON
Reference number: E20438939
Claim ID 251578515500
DOS 06/17/2025

Please Send

All necessary information must be received as soon as possible, but no later than 45 days from the date of the initial request for information.

Please send a copy of the treatment notes for the submitted procedure(s).

Please state procedures and teeth numbers associated with need for anesthesia

***** DO NOT FAX X-RAY IMAGES. Please e-mail X-RAY images*****

Please fax all requested information to the attention of Customer Service at (609) 225-5432 (DO NOT FAX X-RAYS) or e-mail via customerservice@pandrdental.com. If you have any questions, please call us at (609) 783-9004.

If we do not receive the requested information, or if information is missing, the claim request may be denied due to lack of information.*

To cancel this request or for answers to your questions, please contact our staff at the number referenced above. Thank you.