JOHNS HOPKINS
EMPLOYER HEALTH PROGRAMS
sponsored by Johns Hopkins Medicine

Mail to: Employer Health Programs
6704 Curtis Court
Glen Burnie, MD 21060
410-424-4400
toll free 800-261-2393

DENTAL CLAIM FORM

CHECK ONE:

☐ Pretreatment estimate (please submit radiographs/models)

☐ Statement of actual service

PATIENT COVERAGE INFORMATION

1. Patient name (first, middle, last)	2. Relationship to employee	3. Sex	4. Patient's birthdate	5. Employee I.D.#
	☐ self ☐ child ☐ spouse ☐ other	☐ Male ☐ Female		

6. Employee name and mailing address	7. Group number

8. Is patient covered by another dental plan? ☐ Yes ☐ No If Yes, complete 8-12 Is patient covered by a medical plan? ☐ Yes ☐ No	9. Name and address of other dental plan carriers.

10. Employee/name of other plan (if different than patient's)	11. Employee social security or I.D. #	12. Relationship to patient ☐ self ☐ child ☐ spouse ☐ Other_____

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

►_____
Signed (Patient or parent if minor) Date

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

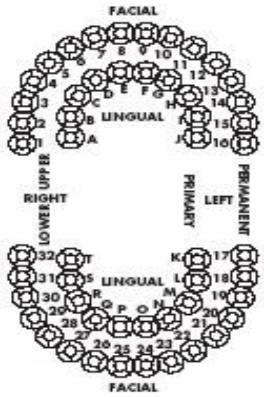
►_____
Signed (Patient or parent if minor) Date

BILLING DENTIST

13. Name of billing dentist or dental entity			21. Is treatment result of occupational illness? Or injury?	No	Yes	If yes, enter brief description and dates	
14. Address where payments should be remitted			22. Is treatment result of auto accident?				
City, State, Zip			23. Other accident?				
15. Dentist Soc. Security # or T.I.N.	16. Dentist License #	17. Dentist phone #	24. If prosthesis, is this initial placement?			(If no, reason for replacement)	28. Date of prior placement
18. First visit date, current series	19. Place of treatment ☐ Office ☐ Hospital ☐ ECF ☐ Other	20. Radiographs or models enclosed? ☐ No ☐ Yes How many? _____	25. Is treatment for orthodontics?			If services already commenced enter: / Date appliances placed / Months treatment remaining	

26. Examination and treatment plan (list in order from tooth # 1 through tooth #32) Use charting system shown.

Identify missing teeth with "X"



Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date of service performed MO DAY YR	Procedure Number	Fee	FOR ADMINISTRATIVE USE ONLY

27. Remarks for unusual services

I hereby certify that the procedure(s) as indicated by date have been completed and that the fee(s) submitted are the actual fee(s). I have charged and intend to collect for those procedures.

►_____
Signed (treating dentist) Date

TOTAL FEE CHARGED