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CHECK ONE: <input type="checkbox"/> Pretreatment estimate (please submit radiographs/models) <input type="checkbox"/> Statement of actual service											
PATIENT COVERAGE INFORMATION	1. Patient's name		2. Relationship to employee <input type="checkbox"/> SELF <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER _____		3. Sex <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		3. Patient's birthdate ____/____/____ Month Day Year				
	5. Employee/member name and mailing address			5.A. Employee I.D.#		6. Group number/name					
	7. Is patient covered by another dental plan? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete 8-12 Is patient covered by a medical plan? <input type="checkbox"/> YES <input type="checkbox"/> NO			8. Name and address of other dental plan carriers.			9. Other group #(s)				
	10. Employee/name of other plan (if different than patient's)			11. Employee/social security or I.D. # _____			12. Relationship to patient <input type="checkbox"/> SELF <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> 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				18. Is treatment result of occupational illness? Or injury?		No	Yes	If yes, enter brief description and dates		
	14. Address where payment should be remitted City, State, Zip				19. Is treatment result of auto accident?						
					20. Other accident?						
	15. Dentist Soc. Security # or T.I.N.		16. Dentist license #		17. Dentist phone		21. Radiographs or models enclosed?			How many?	
NARRATIVE DESCRIPTION OF DIAGNOSIS, TREATMENT AND OTHER SERVICES						PROCEDURE #		FEE		FOR ADMINISTRATIVE USE ONLY	
						EXAMINATION:					
DIAGNOSTIC RECORDS:											
CONSULTATION:											
INITIAL PAYMENT:											
MONTHLY:											
QUARTERLY:											
OTHER PAYMENT PLAN:											
TYPE OF TREATMENT (check one) <input type="checkbox"/> INTERCEPTIVE <input type="checkbox"/> TRANSITIONAL <input type="checkbox"/> COMPREHENSIVE PHASE OF TREATMENT (check one) <input type="checkbox"/> SINGLE PHASE TREATMENT <input type="checkbox"/> MULTIPHASE STARTING DATE OF TREATMENT: _____ LENGTH OF TREATMENT: _____						TOTAL FEE CHARGED					
I hereby certify that the procedure(s) as indicated by date are in progress and that the fee(s) submitted are the actual fee(s) I have charged and intend to collect for those procedures. _____ Signature of Dentist Date						MAX. ALLOWABLE					
						DEDUCTIBLE					
						CARRIER %					
						CARRIER PAYS					
						PATIENT PAYS					

