

1. <input type="checkbox"/> Dentist's pre-treatment estimate <input type="checkbox"/> Dentist's statement of actual services	Specialty (see backside)	3. Carrier Name Florida Combined Life
2. <input type="checkbox"/> Medicaid Claim <input type="checkbox"/> EPSDT	Prior Authorization #	4. Carrier Address P.O. Box 100135
		5. City Columbia
		6. State SC
		7. Zip 29202-3135

PATIENT	8. Patient Name (Last, First, Middle)			9. Address			10. City			11. State					
	12. Date of Birth (MM/DD/YYYY) / /			13. Patient ID#			14. Sex <input type="checkbox"/> M <input type="checkbox"/> F			15. Phone Number ()			16. Zip Code		
	17. Relationship to Subscriber/Employee: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____						18. Employer/School Name _____ Address _____								

SUBSCRIBER/EMPLOYEE	19. Subs./Emp. ID#/SSN#		20. Employer Name		21. Group #		OTHER POLICIES	31. Is Patient covered by another plan <input type="checkbox"/> No (Skip 32-37) <input type="checkbox"/> Yes; <input type="checkbox"/> Dental or <input type="checkbox"/> Medical			32. Policy #						
	22. Subscriber/Employee Name (Last, First, Middle)							33. Other Subscriber's Name									
	23. Address				24. Phone Number ()				34. Date of Birth (MM/DD/YYYY) / /		35. Sex <input type="checkbox"/> M <input type="checkbox"/> F		36. Plan/Program Name				
	25. City			26. State		27. Zip Code		37. Employer/School Name _____ Address _____									
	28. Date of Birth (MM/DD/YYYY) / /			29. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other				30. Sex <input type="checkbox"/> M <input type="checkbox"/> F		38. Subscriber/Employee Status <input type="checkbox"/> Employed <input type="checkbox"/> Part-time Status <input type="checkbox"/> Full-time Student <input type="checkbox"/> Part-time Student							
	39. 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 plan, unless the treating dentist or dental practice has a contractual agreement with y plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim. X _____ Singed (Patient/Guardian) Date (MM/DD/YYYY)								40. Employer/School Name _____ Address _____					41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity. X _____ Signed (Employee/subscriber) Date (MM/DD/YYYY)			

BILLING DENTIST	42. Name of Billing Dentist or Dental Entity				43. Phone Number ()				44. Provider ID #		45. Dentist Soc. Sec. Or T.I.N.				
	46. Address				47. Dentist License #				48. First visit date of current series:		49. Place of treatment <input type="checkbox"/> Office <input type="checkbox"/> Hosp. <input type="checkbox"/> ECF <input type="checkbox"/> Other				
	50. City			51. State		52. Zip Code		53. Radiographs or models enclosed? <input type="checkbox"/> Yes, How many? _____ <input type="checkbox"/> No				54. Is treatment for orthodontics? <input type="checkbox"/> Yes <input type="checkbox"/> No If service already commenced: Date appliances placed _____ Total mos. of treatment remaining _____			
	55. If prosthesis (crown, bridge, dentures), is this initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, reason for replacement: _____ Date of prior replacement: _____								Date appliances placed _____ Total mos. of treatment remaining _____						
	56. Is treatment result of occupational illness or injury? <input type="checkbox"/> No <input type="checkbox"/> Yes Brief Description and dates _____				57. Is treatment result of: <input type="checkbox"/> auto accident? <input type="checkbox"/> other accident? <input type="checkbox"/> neither Brief description and dates _____										

58. Diagnosis Code Index (optional)
 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____

59. Examination and treatment plans - List teeth in order													Admin Use Only														
Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee																				
60. Identify all missing teeth with "X"																											
Permanent								Primary				Total Fee															
1	2	3	4	5	6	7	8	9	10	11	12	13		14	15	16	A	B	C	D	E	F	G	H	I	J	Payment by other plan
32	31	30	29	28	27	25	24	23	22	21	20	19		18	17	T	S	R	Q	P	O	N	M	L	K	Max. Allowable	
61. Remarks for unusual services																											

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures X _____ Signed (Treating Dentists) License # _____ Date (MM/DD/YYYY) _____			63. Address where treatment was performed		
64. City		65. State	66. Zip Code		