

2. MEMBER INFORMATION		
1. Member's No. ¹ <input style="width: 100%; height: 20px;" type="text"/>	Member / Patient's Name (First) ³ <input style="width: 100%; height: 20px;" type="text"/>	MI <input style="width: 20px; height: 20px;" type="text"/>
TRN ² <input style="width: 100%; height: 20px;" type="text"/>	(Last) ³ <input style="width: 100%; height: 20px;" type="text"/>	
3. Is patient covered by another Insurance Co.? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, complete 3-a and 3-b	3-a. Name and Address of Other Carrier(s)	3-b. Other Group/Policy No.
I hereby authorize the release of any information relating to this claim. _____ Signed (Patient or Parent, if minor) Date _____	I hereby authorize payment of the Dental benefits directly to the below named Dental provider: _____ Signed (Patient or Parent, if minor) Date _____	
4. Name of Provider.	9. Referring Provider	
5. Address where payment should be remitted. City _____	10.	
6. Provider TRN:	7. Provider GCT No.:	8. Provider Tel. No.:

* HCPS 2005

11. TO BE COMPLETED BY DENTIST:						
-07 08 09 10- -06 11- -05 Upper 12- -04 13- -03 14- -02 15- -01 Right 35- Left 16- -32 36- 17- -31 37- 18- -30 38- 19- -29 20- -28 Lower 21- -27 22- -26 25 24 23-	Date of Service	Tooth # or Letter	Surface	Description of Service	Procedure Code	Charges
				Periodic oral Examination	D0120	
				Intraoral (Complete Series)	D0210	
				Intraoral (First Film)	D0220	
				Intraoral (Each Additional Film)	D0220	
				Bitewings (Two Films)	D0272	
				Bitewings (Four Films)	D0274	
				Prophylaxis (Adult)	D1110	
				Prophylaxis (Child)	D1120	
				Amalgam (One Surface)	D2140	
				Amalgam (Two Surfaces)	D2150	
				Amalgam (Three Surfaces)	D2160	
12. CERTIFICATION - THIS FORM MUST BE SIGNED BY THE PROVIDER OR AUTHORIZED PERSON					TOTAL CHARGE	\$
I hereby certify that the above services, as indicated by date, have been completed.					INSURANCE PLAN PAYS	\$
_____					GCT ON INS. PAYMENT	\$
Signature of Provider or Authorized Person Provider Stamp					TOTAL PAYABLE BY INS. CO.	\$
_____					MEMBER PAYS	\$
Date						

PLEASE ATTACH ORIGINAL RECEIPTS TO ENSURE TIMELY PROCESSING OF CLAIMS.
CLAIMS MUST BE SUBMITTED WITHIN 90 DAYS OF FIRST SERVICE DATE TO ENSURE PROMPT PROCESSING.