

Preferred Gold HMO-POS, GoldAnywhere PPO and USA Care PPO Dental Claim Form



HEADER INFORMATION		OTHER COVERAGE	
1. Type of Transaction (Check all applicable boxes) <input type="checkbox"/> Statement of Actual Services - OR - <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT/Title XIX		9. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 10-16) <input type="checkbox"/> Yes (Complete 10-16)	
2. Predetermination/Preauthorization Number		10. Subscriber in #4 (Last, First, Middle Initial, Suffix)	
PAYER INFORMATION		11. Date of Birth (MM/DD/CCYY)	12. Gender <input type="checkbox"/> M <input type="checkbox"/> F
3. Name, Address, City, State, Zip Code Preferred Gold HMO-POS, GoldAnywhere PPO and USA Care PPO 1050 University Avenue, Suite A Rocheste , NY 14607 Electronic Payor ID 16112		13. Subscriber Identifier (SSN or ID#)	
SUBSCRIBER INFORMATION		14. Plan/Group No.	15. Relationship to Primary Subscriber in #5 (Check applicable box) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other
4. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code		16. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	
5. Date of Birth (MM/DD/CCYY)	6. Gender <input type="checkbox"/> M <input type="checkbox"/> F	7. Subscriber Identifier (SSN or ID#)	
8. Plan/Group No.			
AUTHORIZATIONS			
17. 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 prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.		18. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.	
X _____ Patient/Guardian Signature Date		X _____ Subscriber Signature Date	

RECORD OF SERVICES PROVIDED

PATIENT: ATTACH A COPY OF YOUR BILL OR STATEMENT HERE

19. Procedure Date (MM/DD/CCYY)	20. Area of Oral Cavity	21. Tooth System	22. Tooth Number(s) or Letter(s)	23. Tooth Surface	24. Procedure Code	25. Description	26. Fee
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

27. (Place an "X" on each missing tooth)	<u>Permanent</u>																<u>Primary</u>										28. Other Fee(s)	29. 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		
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K		

30. Remarks

ANCILLARY CLAIM / TREATMENT INFORMATION

31. Place of Treatment (Check appropriate box) <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other		32. Number of Enclosures Radiographs _____ Oral Image(s) _____ Model(s) _____		33. Is Treatment for Orthodontics <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)		34. Date Appliance Placed (MM/DD/CCYY)	
35. Months of Treatment Remaining		36. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)		37. Date Prior Placement (MM/DD/CCYY)		38. Treatment Resulting from (Check appropriate box) <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident	
39. Date of Accident (MM/DD/CCYY)				40. Auto Accident State			

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

41. 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 Dentist) Date

42. NPI	43. License Number
44. Address, City, State, Zip Code	
45. Provider Specialty Code	
46. Phone Number () -	47. Additional Provider ID