

ATTENDING DENTISTS STATEMENT



HEALTHCARE Management Administrators, Inc.

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CHECK ONE:

- DENTIST'S PRE-TREATMENT ESTIMATE
 DENTIST'S STATEMENT OF ACTUAL SERVICES

PATIENT NAME		RELATIONSHIP TO EMPLOYEE SELF, SPOUSE, CHILD, OTHER	SEX M, F	PATIENT BIRTHDATE MO, DAY, YEAR	IF FULL TIME STUDENT SCHOOL	CITY
EMPLOYEE/SUBSCRIBER NAME FIRST MIDDLE LAST				EMPLOYEE/SUBSCRIBER SOCIAL SECURITY NO.	Healthcare Management Administrators, Inc.	
EMPLOYEE/SUBSCRIBER MAILING ADDRESS				EMPLOYER (COMPANY) NAME AND ADDRESS		
CITY, STATE, ZIP						
GROUP NUMBER	ARE OTHER FAMILY MEMBERS EMPLOYED? EMPLOYEE NAME		SOC SEC NO	NAME & ADDRESS OF SPOUSES' EMPLOYER		
IS PATIENT COVERED BY ANOTHER DENTAL PLAN?	DENTAL PLAN NAME	UNION LOCAL	GROUP NO.	NAME & ADDRESS OF CARRIER		

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.				I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.			
_____ SIGNED (PATIENT, OR PARENT IF MINOR)				_____ SIGNED (INSURED PERSON)			
DATE				DATE			
DENTIST NAME				Is treatment result of occupational illness or injury?	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
MAILING ADDRESS				Is treatment result of auto accident?			
CITY, STATE, ZIP				Other accident?			
DENTIST SOC. SEC OR T.I.N.				DENTIST LICENSE NO.	DENTIST PHONE NO.	(IF NO, REASON FOR REPLACEMENT) Date of prior placement	
FIRST VISIT DATE CURRENT SERIES	PLACE OF TREATMENT OFF, HOSP, ECF, OTHER	RADIOGRAPHS OR MODELS ENCLOSED?	YES	NO	HOW MANY	Is treatment for Orthodontics?	If services already commenced enter
							Date appliances placed
							Mos. treatment remaining

Identify missing teeth with "X" FACIAL > 7 > 8 > 9 > 10 > 11 > > 5 > 6 > 7 > 8 > 9 > 10 > 11 > > 4 > 5 > 6 > 7 > 8 > 9 > 10 > 11 > > 3 > 4 > 5 > 6 > 7 > 8 > 9 > 10 > 11 > > 2 > 3 > 4 > 5 > 6 > 7 > 8 > 9 > 10 > 11 > > 1 > 2 > 3 > 4 > 5 > 6 > 7 > 8 > 9 > 10 > 11 > UPPER RIGHT LOWER LINGUAL PERMANENT PRIMARY LEFT > 32 > T > K > 17 > > 31 > S > L > 18 > > 30 > R > M > 19 > > 29 > Q > N > 20 > > 28 > P > O > 21 > > 27 > > 22 > > 26 > 25 > 24 > 23 > > > > > FACIAL Remarks for unusual services	EXAMINATION AND TREATMENT PLAN - List in order from tooth No. 1 through tooth No. 32 - use charting system shown.								
	Tooth # of Letter	Surface	DESCRIPTION OF SERVICE (including X-Rays, Prophylaxis, Materials used, Etc.)	Date of Service Performed MO DAY YR			Procedure Number	Fee	Amount Certified

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED.		TOTAL FEE CHARGED
_____ SIGNED (DENTIST)	DATE _____	
		MAX ALLOWABLE
		DEDUCTIBLE
		CARRIER %
		CARRIER PAYS
		PATIENT PAYS