



BeneCare[®]

DENTAL PLANS

615 CHESTNUT STREET, SUITE 1001
PHILADELPHIA, PA 19106
(215) 440 - 1000

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)

- Statement of Actual Services - OR - Request for Predetermination / Preauthorization
- EPSDT / Title XIX

2. Predetermination / Preauthorization number

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code

PRIMARY SUBSCRIBER INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City State, Zip Code

13. Date of Birth (MM/DD/CCYY)

14. Gender

- M F

15. Subscriber Identifier (SSN or ID#)

OTHER COVERAGE

4. Other Dental Coverage? No (skip 5 - 11) Yes (complete 5 - 11)

5. Subscriber Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)

7. Gender

- M F

8. Subscriber Identifier (SSN or ID#)

9. Plan / Group Number

10. Relationship to Primary Subscriber (Check applicable box)

- Self Spouse Dependent Other

11. Other Carrier Name, Address, City, State, Zip Code

PATIENT INFORMATION

18. Relationship to Primary Subscriber (Check applicable box)

- Self Spouse Dependent Other

19. Student Status

- FTS PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City State, Zip Code

21. Date of Birth (MM/DD/CCYY)

22. Gender

- M F

23. Subscriber Identifier (SSN or ID#)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)	Permanent																Primary										32. Other Fee(s)
	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	
																	T	S	R	Q	P	O	N	M	L	K	

35. Remarks

AUTHORIZATIONS

36. 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 my dental benefit 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 a discloser of my protected health information to carry out payment activities in connection to this claim.

X _____
Patient / Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity

X _____
Subscriber Signature Date

ANCILLARY CLAIM / TREATMENT INFORMATION

38. Place of Treatment (Check applicable box)

- Provider's Office Provider's Office ECF Other

39. Number of Enclosures (00 to 99)

- Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics?

- No (Skip 41-42) Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis

- No Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box)

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OF DENTAL ENTITY (Leave blank, if dentist or dental entity is not submitting claim on behalf of the patient or insured / subscriber)

48. Name, Address, City, State, Zip Code

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. 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 fee submitted are the actual fees I have charged and intend to collect for those procedures.

X _____
Signed (Treating Dentist) Date

54. Provider ID

55. License Number

49. Provider ID

50. License Number

51. SSN or TIN

56. Address, City, State, Zip Code

52. Phone Number

57. Phone Number

58. Treating Provider Specialty