BlueCross BlueShield of Louisiana
An independent licensee of the Blue Cross and Blue Shield Association.

P. O. BOX 98029
BATON ROUGE, LA 70898-9029
225/295-3307

ATTENDING DENTIST'S STATEMENT

CHECK ONE:
- ❑ **DENTIST'S PRE-TREATMENT ESTIMATE**
- ❑ **DENTIST'S STATEMENT OF ACTUAL SERVICES**

CARRIER-NAME AND ADDRESS:

PATIENT SECTION

1. PATIENT NAME
2. RELATIONSHIP TO EMPLOYEE: SELF | SPOUSE | CHILD | OTHER
3. SEX: M | F
4. PATIENT BIRTHDATE: MO | DAY | YEAR
5. IF FULL TIME STUDENT: SCHOOL CITY
6. EMPLOYEE/SUBSCRIBER NAME: FIRST MIDDLE LAST
7. EMPLOYEE SSN/ SUBSCRIBER BLUE CROSS AND BLUE SHIELD OF LOUISIANA CONTRACT NUMBER
8. EMPLOYEE/SUBSCRIBER MAILING ADDRESS
9. NAME OF GROUP DENTAL PROGRAM
CITY, STATE, ZIP
10. EMPLOYER (COMPANY) NAME AND ADDRESS
11. GROUP NUMBER
12. LOCATION (LOCAL)
13. ARE OTHER FAMILY MEMBERS EMPLOYED? ❑ YES ❑ NO — EMPLOYEE NAME — SSN
14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13
15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ❑ YES ❑ NO — DENTAL PLAN NAME — UNION LOCAL — GROUP NUMBER — NAME AND ADDRESS OF CARRIER

FOR OFFICE USE ONLY

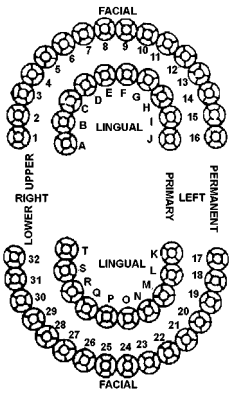
I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

X _____ _____
SIGNATURE (PATIENT, OR PARENT IF MINOR) DATE

DENTIST SECTION

16. DENTIST NAME
17. MAILING ADDRESS
CITY, STATE, ZIP
18. DENTIST SSN OR T.I.N.
19. DENTIST PROVIDER NO.
20. DENTIST PHONE NO.
21. FIRST VISIT DATE CURRENT SERIES
22. PLACE OF TREATMENT: OFFICE | HOSP | ECF | OTHER
23. RADIOGRAPHS OR MODELS ENCLOSED? NO | YES | HOW MANY?
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? NO | YES — IF YES, ENTER BRIEF DESCRIPTION AND DATES
25. IS TREATMENT RESULT OF AUTO ACCIDENT? NO | YES
26. OTHER ACCIDENT? NO | YES
27. ARE ANY SERVICES COVERED BY ANOTHER PLAN? NO | YES
28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? NO | YES — (IF NO. REASON FOR REPLACEMENT) 29. DATE OF PRIOR PLACEMENT
30. IS TREATMENT FOR ORTHODONTICS? NO | YES — IF SERVICES ALREADY COMMENCED, ENTER: DATE APPLIANCES PLACED; MOS. TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X"



32. REMARKS FOR UNUSUAL SERVICES

31. EXAMINATION AND TREATMENT PLAN -- LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 - USE CHARTING SYSTEM SHOWN.

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) LINE NO.	DATE SERVICE PERFORMED MO DAY YEAR	PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY THE DATE HAVE BEEN COMPLETED.

X _____ _____
DENTIST SIGNATURE DATE

TOTAL FEE CHARGED	
MAX. ALLOWABLE	
DEDUCTIBLE	
CARRIER %	
CARRIER PAYS	
PATIENT PAYS	

Form Approved by the Council on Dental Programs of the A.D.A.

Blue Cross and Blue Shield of Louisiana incorporated as Louisiana Health Service & Indemnity Company