CRESCENT HEALTH SOLUTIONS

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Asheville, NC 28806
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DENTAL CLAIM FORM

TO BE COMPLETED BY EMPLOYEE – USE BLACK INK ONLY

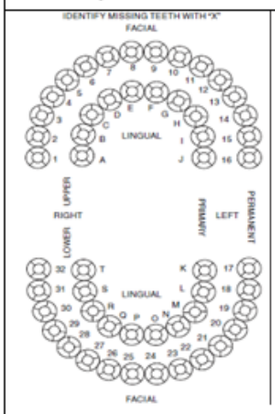
1. Employer's Name Jackson County			2. Policy/Group # 0210.
3. Employee's ID	4. Employee's Name		5. Employee's Birthdate (MM/DD/YYYY)
6. ☐ Active ☐ Retired Date Retired	7. Employee's Full Address ☐ New Address		8. Employee's Daytime Phone ( )
9. Patient's Name	10. Patient's ID #	11. Patient's Birthdate	12. Patient's Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other
13. Patient's Address (if different from Employee)	14. Patient's Sex ☐ Male ☐ Female	15. Full-time Student ☐ Yes ☐ No	16. Graduating Date 17. School/City
18. Patient's Marital Status ☐ Married ☐ Single	19. Is Patient Employed? ☐ No ☐ Yes		20. Employer Name & Address
21. Is claim related to an accident? ☐ No ☐ Yes Date of accident Time ☐ AM ☐ PM			22. Is claim related to employment? ☐ No ☐ Yes
23. Are any family members' expenses covered by another group health plan, group pre-payment plan (BCBS, etc.), no-fault auto insurance, Medicare or any federal, state, or local government plan? ☐ No ☐ Yes			
24. If yes, provide policy/contract holder name, policy number, and name/address of Company/administrator			
25. Member's ID #	26. Member's Name		27. Member's Birthdate
28. I authorize payment of dental benefits to the dentist or supplier of service. ➡ *Patient/Authorized Person Signature* *Date*			

TO BE COMPLETED BY DENTIST – USE BLACK INK ONLY

30. This a request for ☐ Pre-Treatment Estimate ☐ Predetermination/Preauthorization # ☐ Services Rendered			
31. Dentist's Name & Full Address	32. NPN #	33. License #	34. Phone ( )
	35. Taxpayer ID for 1099 Reporting (required by law)		
	36. First Visit Date Current Series	37. Place of Treatment ☐ Office ☐ Hospital ☐ ECF ☐ Other	
	38. Radiographs or models enclosed? ☐ No ☐ Yes How Many?		

Is treatment the result of	No	Yes	If yes, enter brief description and dates	
39. Occupational illness or injury				
40. Auto accident				
41. Other accident				
42. Are any services covered by another plan?				
43. If prosthesis, is this initial placement?			If no, date of prior placement/reason for replacement	
44. Is treatment for orthodontics?			Date appliance placed	Initial Appliance Fee
			No. months of treatment	Monthly Fee
			No. months remaining	Total Case Fee

45. To expedite claim handling, identify all missing teeth with 'X'.



46. Examination/treatment plan. List in order, tooth # 1 - 32.

Tooth #/ Letter	Date previously extracted	Surface	Description of Service (xray, prophylaxis, materials used, etc.)	Date Service Performed MM	DD	YYYY	Procedure #	Fee

47. I hereby certify that the procedures as indicated by date have been completed, and that the fees submitted are the actual fees I have charged this patient and intend to accept for those procedures.
➡ *Dentist's Signature* *Date*

48. NPN #

Total charge $ _____
Amount paid $ _____
Balance due $ _____