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

United Concordia
Dental Claims Administrator
PO Box 69441
Harrisburg, PA 17106-9441

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

CITY, STATE, ZIP

9. NAME OF GROUP DENTAL PROGRAM

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.

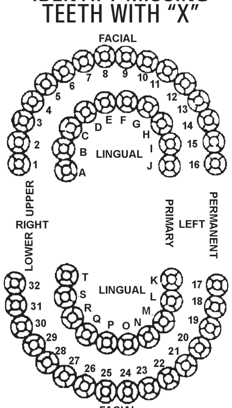
21. FIRST VISIT DATE CURRENT SERIES

22. PLACE OF TREATMENT: OFFICE | HOSP | ECF | OTHER

23. RADIOGRAPHS OR MODELS ENCLOSED? NO | YES | HOW MANY?

	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
25. IS TREATMENT RESULT OF AUTO ACCIDENT?			
26. OTHER ACCIDENT?			
27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) 29. DATE OF PRIOR PLACEMENT
30. IS TREATMENT FOR ORTHODONTICS?			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.