Mail this form to: Anthem Blue Cross and Blue Shield
P.O. 547
North Haven, CT 06473

Toll Free Tel: 1-888-799-6290

Attending Dentist Statement

Check one:
- ☐ Dentist pre-treatment estimate
- ☐ Dentist statement of actual services

PATIENT

PATIENT NAME (First, Middle, Last)	RELATIONSHIP TO SUBSCRIBER	SEX	PATIENT BIRTHDATE	IF FULL TIME STUDENT
	☐ Self ☐ Child ☐ Spouse ☐ Other	☐ M ☐ F	Month Day Year	School Name, City

SUBSCRIBER NAME AND MAILING ADDRESS	SUBSCRIBER IDENTIFICATION NUMBER	SUBSCRIBER BIRTHDATE	EMPLOYER (COMPANY) NAME AND ADDRESS	GROUP NUMBER
ADDRESS CHANGE (CHECK HERE) ☐		Month Day Year	Yale University 155 Whitney Ave., Rm 130 New Haven, CT 06520	800187

PATIENT COVERED BY ANOTHER DENTAL PLAN?	NAME AND ADDRESS OF CARRIER	GROUP NUMBER	NAME AND ADDRESS OF EMPLOYER
☐ Yes ☐ No			

SUBSCRIBER NAME (if different than patient's)	SUBSCRIBER IDENTIFICATION NUMBER	SUBSCRIBER BIRTHDATE	RELATIONSHIP TO PATIENT
		Month Day Year	☐ SELF ☐ PATIENT ☐ SPOUSE ☐ OTHER _____

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

Signed (Patient or parent if minor) Date

I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.

Signed (Insured person) Date

DENTIST

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? OTHER ACCIDENT?			
CITY, STATE, ZIP	IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			If no, reason for replacement
DENTIST SOC.SEC.OR T.I.N. DENTIST LICENSE NO. DENTIST PHONE NUMBER	DATE OR PRIOR PLACEMENT?			
FIRST VISIT CURRENT SERIES — PLACE OF TREATMENT: Office / Hosp / ECF / Other — RADIOGRAPHS OR MODELS ENCLOSED? NO YES HOW MANY?	IS TREATMENT FOR ORTHODONTICS?			If services already commenced / Date appliances placed / Months treatment remaining

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	Date Service performed MO. Day Year	Procedure Number	Fee	For Administrative Use Only: DED COPAY	Benefit Amount

I hereby certify that the procedure as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for these procedures.

Signed (Treating Dentist) Date

Total Fee Charged	
Max. Allowable	
Deductible	NONE
Carrier pays	
Patient pays	