

# ATTENDING DENTIST'S STATEMENT

**Important: Please read second page for information on filing and instructions for completing this claim form.**

<b>Check One:</b> <input type="checkbox"/> Dentist's pre-treatment estimate <input type="checkbox"/> Dentist's statement of actual services		Carrier name and Address ACS Benefit Services Inc P O Box 2000 Winston-Salem, NC 27102-2000			Electronically File Dental Claims: WebMD Payer # 72468		
P A R T 1	1. Member / Patient name first m.i. last		2. Relation to Subscriber <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse <input type="checkbox"/> other		3. Sex m f <input type="checkbox"/> <input type="checkbox"/>		
	4. Member birthdate MM DD YYYY		5. If full time student school city				
	6. Employee / Subscriber name and mailing address		7. Employee / Subscriber soc sec number		8. Employee / Subscriber birthdate MM DD YYYY		
	9. Employer (company) name		10. Group NO.				
11. Is Member covered by another dental plan? If yes, complete 12-A through 15. <input type="checkbox"/> Yes <input type="checkbox"/> No		12-A. Name and address of carrier(s)		12-B. Group No.(s)		13. Name and address of Employer	
14-A. Other Coverage: Employee / Subscriber name (if different from Member's)		14-B. Employee / Subscriber soc sec number		14-C. Employee / Subscriber birthdate MM DD YYYY		15. Relationship to Member <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse <input type="checkbox"/> 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.  <b>X</b> Signed (Adult Member, or Parent of minor Member)				I hereby authorize payment directly to the below named dentist of the group benefits otherwise payable to me.  <b>X</b> Signed (Adult Member, or Parent of minor Member)			
P A R T 2	16. Name of Billing Dentist or Dental Entity			24. Is treatment result of occupational illness or injury?		No Yes If yes, enter brief description and dates	
	17. Address where payment should be remitted  City, State, Zip			25. Auto accident?			
	18. Dentist Soc Sec or T.I.N.			19. Dentist license No.		20. Dentist phone	
	21. First visit date current series			22. Place of treatment Office Other		23. Radiographs No Yes How Many?	
27. If prosthesis, is this initial placement?			26. Other accident?				
29. Is treatment for orthodontics?							
Identify missing teeth with "X"		30. Examination and treatment plan --- List in order from tooth No. 1 through tooth No. 32 - Use charting system shown.					For admin use only
		Tooth No. or letter	Surface	Description of service (Including x-rays,prophylaxis,etc.) Line No.	Date service performed	Procedure Number	
31. Remarks for unusual services							
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 and intend to collect for those procedures.					Total Fee Charged		
Signature (Treating Dentist)			License Number		Date		Payment by Other Plan

**Please submit the claim form to:**

ACS Benefit Services, Inc.  
P O Box 2000  
Winston-Salem, NC 27102-2000

To submit claims electronically, contact WebMD Transaction Services at (800) 366-5716. Help Desk (800) 845-6592. The payer id is located on the top of the claim form.

## **PART 1 INSTRUCTIONS FOR THE SUBSCRIBER**

1. Complete only Part 1 of the form answering every question. (Please Print)
2. Sign Part 1 of the ATTENDING DENTIST'S STATEMENT, where indicated by the 'X'. There are two signature lines. You should always sign the left signature line. This authorizes the dentist to release information relating to the claim. Sign the signature line on the right if you authorize payment directly to the dentist. If you do not sign on this line, payments will be sent directly to you.
3. Take the form to your dentist on your first visit. The form will be completed by your dentist and sent to the address at the top of the claim form.
4. *Pre-treatment Estimate:* When the carrier returns the form to the dentist, you must make appointments for treatment. Treatment must be completed as soon as possible after you are certified eligible for coverage.

## **PART 2 INSTRUCTIONS FOR THE DENTIST**

1. On the chart provided on the form, indicate all treatments to be performed.
2. Indicate on this chart all missing teeth with an "X" and all abutments with an "O".
3. In the space provided on the form, describe procedures necessary to fully complete treatment of this case using one line for each operation or restoration, and give the fee for each procedure. X-RAYS MUST BE ITEMIZED. (If additional space is required use a separate claim form.)
4. X-rays, when necessary, must accompany the claim form. (Duplicates are acceptable.) Preoperative X-rays for extraction of impacted teeth are required. Postoperative X-rays for completed root canal treatment and filling are required.
5. In the event of an extraction of an impacted tooth, designate the type of impaction (tissue, partial bone, complete bone).
6. AT COMPLETION OF TREATMENT, SIGN THE ORIGINAL OF THE FORM (AT BOTTOM) AND RETURN IT TO THE ADDRESS SHOWN AT THE TOP OF THE CLAIM FORM.