Anthem Blue Cross and Blue Shield is the trade name for the following:
In Connecticut: Anthem Health Plans, Inc.
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In Indiana: Anthem Insurance Companies, Inc.
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In Nevada: Rocky Mountain Hospital and Medical Service, Inc.
In New Hampshire: Anthem Health Plans of New Hampshire, Inc.
In Ohio: Community Insurance Company.
In Virginia: Anthem Health Plans of Virginia, Inc.
Independent licensees of the Blue Cross and Blue Shield Association. ® Registered Marks Blue Cross and Blue Shield Association.

Attending Dentist Statement

SUBMIT TO: P.O. Box 659444, San Antonio, TX 78265-9444

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

PATIENT

1. PATIENT NAME (First, Middle, Last)
2. RELATIONSHIP TO SUBSCRIBER ☐ Self ☐ Child ☐ Spouse ☐ Other
3. SEX ☐ M ☐ F
4. PATIENT BIRTHDATE Month | Date | Year
5. IF FULL TIME STUDENT School Name, City
6. SUBSCRIBER NAME AND MAILING ADDRESS
ADDRESS CHANGE (Check here) ☐
7. SUBSCRIBER IDENTIFICATION NUMBER
8. SUBSCRIBER BIRTHDATE Month | Day | Year
9. EMPLOYER (Company) NAME AND ADDRESS
10. GROUP NUMBER
11. IS PATIENT COVERED BY ANOTHER PLAN OF BENEFITS?
Dental ☐ Yes ☐ No
Medical ☐ Yes ☐ No
12-a NAME AND ADDRESS OF CARRIER(S)
12-b GROUP NUMBER(S)
13. NAME AND ADDRESS OF EMPLOYER
14-a SUBSCRIBER NAME (if different than patient's)
14-b SUBSCRIBER IDENTIFICATION NUMBER
14-c SUBSCRIBER BIRTHDATE Month | Day | Year
15. RELATIONSHIP TO PATIENT ☐ SELF ☐ PARENT ☐ 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

16. DENTIST NAME
17. MAILING ADDRESS
CITY, STATE, ZIP
18. DENTIST SOC.SEC. OR T.I.N.
19. DENTIST LICENSE NO.
20. DENTIST PHONE NUMBER
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	
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			If yes, enter brief description and dates.
25. IS TREATMENT RESULT OF AUTO ACCIDENT?			
26. OTHER ACCIDENT?			
27. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(If No, reason for replacement)
28. DATE OR PRIOR PLACEMENT?			
29. IS TREATMENT FOR ORTHODONTICS?			If services already commenced: / Date appliances placed / Months treatment remaining

Identify missing teeth with "X"

FACIAL
Upper: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16; A B C D E F G H I J; LINGUAL
INDICATE MISSING TEETH WITH "X"
UPPER RIGHT LOWER PRIMARY LEFT PERMANENT
Lower: 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32; K L M N O P Q R S T; LINGUAL
FACIAL

30. 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: DED COPAY	Benefit Amount
		1.				D			
		2.				D			
		3.				D			
		4.				D			
		5.				D			
		6.				D			
		7.				D			
		8.				D			
		9.				D			
		10.				D			
		11.				D			
		12.				D			
		13.				D			
		14.				D			
		15.				D			
						D			
						D			

31. Remarks for unusual services

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	
Carrier pays	
Patient pays	

WHITE/Anthem BCBS – CANARY/Provider

FORM NO. 98668