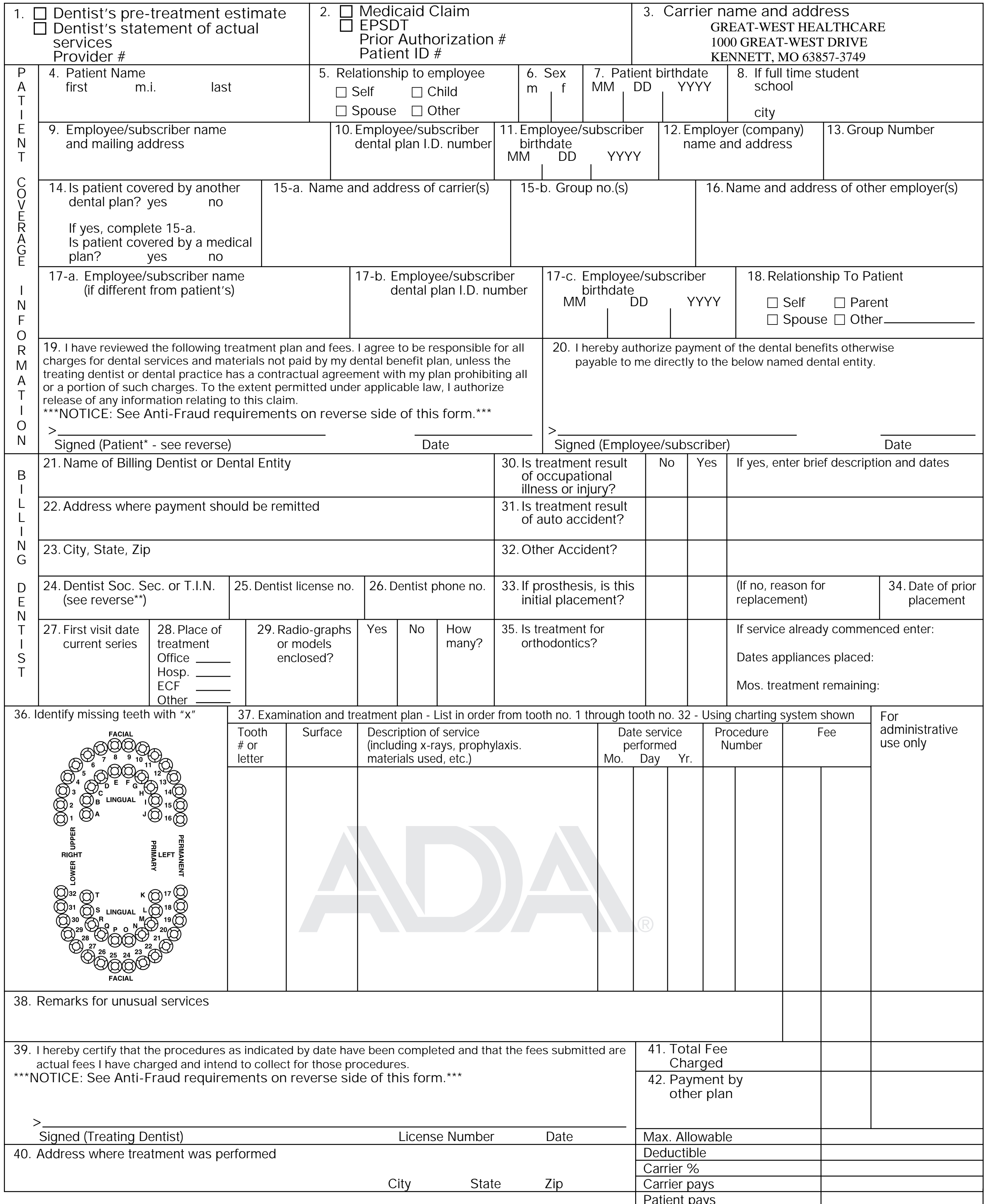
Great-West[SM]
HEALTHCARE

Dental Claim Form

(DO NOT SEND X-RAYS)



1. ☐ Dentist's pre-treatment estimate
☐ Dentist's statement of actual services
Provider #

2. ☐ Medicaid Claim
☐ EPSDT
Prior Authorization #
Patient ID #

3. Carrier name and address
GREAT-WEST HEALTHCARE
1000 GREAT-WEST DRIVE
KENNETT, MO 63857-3749

PATIENT COVERAGE INFORMATION

4. Patient Name: first / m.i. / last	5. Relationship to employee: ☐ Self ☐ Child ☐ Spouse ☐ Other	6. Sex: m / f	7. Patient birthdate: MM / DD / YYYY	8. If full time student: school / city

9. Employee/subscriber name and mailing address	10. Employee/subscriber dental plan I.D. number	11. Employee/subscriber birthdate: MM / DD / YYYY	12. Employer (company) name and address	13. Group Number

14. Is patient covered by another dental plan? yes / no. If yes, complete 15-a. Is patient covered by a medical plan? yes / no	15-a. Name and address of carrier(s)	15-b. Group no.(s)	16. Name and address of other employer(s)

17-a. Employee/subscriber name (if different from patient's)	17-b. Employee/subscriber dental plan I.D. number	17-c. Employee/subscriber birthdate: MM / DD / YYYY	18. Relationship To Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other ______

19. I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.
NOTICE: See Anti-Fraud requirements on reverse side of this form.

>______________________________ ____________
Signed (Patient* - see reverse) Date

20. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

>______________________________ ____________
Signed (Employee/subscriber) Date

BILLING DENTIST

21. Name of Billing Dentist or Dental Entity	30. Is treatment result of occupational illness or injury?	No	Yes	If yes, enter brief description and dates
22. Address where payment should be remitted	31. Is treatment result of auto accident?			
23. City, State, Zip	32. Other Accident?			

24. Dentist Soc. Sec. or T.I.N. (see reverse**)	25. Dentist license no.	26. Dentist phone no.	33. If prosthesis, is this initial placement?			(If no, reason for replacement)	34. Date of prior placement

27. First visit date current series	28. Place of treatment: Office ____ Hosp. ____ ECF ____ Other ____	29. Radio-graphs or models enclosed?	Yes	No	How many?	35. Is treatment for orthodontics?			If service already commenced enter: Dates appliances placed: Mos. treatment remaining:

36. Identify missing teeth with "x"

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

37. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Using charting system shown

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis. materials used, etc.)	Date service performed Mo.	Day	Yr.	Procedure Number	Fee	For administrative use only

38. Remarks for unusual services

39. I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are actual fees I have charged and intend to collect for those procedures.
NOTICE: See Anti-Fraud requirements on reverse side of this form.

>____
Signed (Treating Dentist) License Number Date

40. Address where treatment was performed
City State Zip

41. Total Fee Charged	
42. Payment by other plan	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

ADA®

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Arizona Fraud Notice:
Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California Fraud Notice:
For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Florida Fraud Notice:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho Fraud Notice:
Any person who knowingly, and with intent to injure, defraud, or deceive any insurance company, files a statement containing any false, incomplete or misleading information is guilty of a felony.

New Mexico Fraud Notice:
All claim forms and applications for insurance must contain the following disclosure:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Oregon Fraud Notice:
Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any materially false, incomplete or misleading information maybe guilty of insurance fraud.

Pennsylvania Fraud Notice:
Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any false information or conceals for the purpose of misleading, information concerning and fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee Fraud Notice:
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.