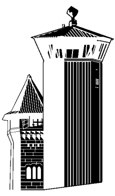

CCPOA Benefit Trust Fund

2515 Venture Oaks Way, Suite 200
Sacramento, CA 95833-4235
www.ccpoabtf.org

REMEMBER YOU MUST:
1. Sign 2. Date
3. Mail completed form to the Trust.

CHECK ONE:
❑ DENTIST'S PRE-TREATMENT ESTIMATE
❑ DENTIST'S STATEMENT OF ACTUAL SERVICES

Dental Claim Form

1. PATIENT NAME LAST FIRST MIDDLE
2. RELATIONSHIP TO EMPLOYEE SELF | SPOUSE | CHILD | OTHER
3. SEX M | F
4. PATIENT BIRTHDATE MO. | DAY | YEAR

5. INSURED SUBSCRIBER NAME LAST FIRST MIDDLE
6. SUBSCRIBER ID#
8. NAME OF GROUP DENTAL PROGRAM

7. INSURED MAILING ADDRESS PHONE NUMBER
9. EMPLOYER (COMPANY) NAME AND ADDRESS

CITY STATE ZIP

10. GROUP NUMBER
11. ARE OTHER FAMILY MEMBERS EMPLOYED? EMPLOYER NAME SOC. SEC. NO.
12. NAME AND ADDRESS OF EMPLOYER IN ITEM 11

13. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ❑ YES ❑ NO | DENTAL PLAN NAME | OTHER SUBSCRIBERS'S NAME | GROUP NO. | NAME AND ADDRESS OF CARRIER | OTHER CARRIER POLICY NO. | OTHER CARRIER AMT. PAID

14. 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.

> Signed (Patient* - see reverse) Date

15. 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

16. Name of Billing Dentist or dental Entity
17. Address where payment should be remitted
18. City, State, Zip
19. Dentist Soc. Sec. OR T.I.N.
20. Dentist license no.
21. Dentist phone no.
22. First visit date current series
23. Place of treatment plan Office Hosp ECF Other
24. Radiographs or models enclosed? No Yes How many

	No	Yes
25. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		
26. IS TREATMENT RESULT OF AUTO ACCIDENT? 27. OTHER ACCIDENT?		
28. ARE ANY SERVICES COVERED BY ANOTHER PLAN?		
29. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? IF NO, REASON FOR REPLACEMENT		
31. IS TREATMENT FOR ORTHODONTICS?		

ORTHODONTICS - ACTIVE TREATMENT

Dates Bands Were Placed	Monthly Charge $
Date Appliance Inserted	Fee For Appliance $
Estimated Total Months of Treatment	Total Fee (including application) $

30. DATE OF PRIOR PLACEMENT

IF SERVICES ALREADY COMMENCED ➔ ENTER | DATE APPLIANCES PLACED | MOS. TREATMENT REMAINING

32. Identify missing teeth with "x"

FACIAL
UPPER
LINGUAL
RIGHT PRIMARY LEFT PERMANENT
LOWER
LINGUAL
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
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

33. 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 Year	Procedure Number	Fee	For administrative use only

34. Remarks for unusual services

TOTAL FEE ACTUALLY CHARGED		
PATIENT PAYS		▶
BALANCE		

35. 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.

> Signed (Treating Dentist) Date

36. Address where treatment was performed City State Zip

ZVCCPOA 3003