## OUT-OF-COUNTRY CLAIM Route for Foreign Claim Processing. ATTENDING DENTIST'S STATEMENT

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	neck one:							Carrier	name an	d add	ress					EM BCB OX 1115	S DENTAL CLAIMS
	Dentist's pre-treatm																S MN 55440-1115
V		of act	ual serv	/ices											USA		
P A T	1. Patient name  first	m.i.		last	_	Relationship to	_ ' ' '	·  -			oirthdat	$\vee$		If full time st school	tudent		
ΙŢ							child	m	f M	М	DD	`YYY 	Y	city			
E N					L	_ spouse _ L	other			_				•			
ĮΫ	6. Employee/subscriber nar	ne and n	ailing add	ress	7.	. Employee/sub		B. Employee/s	ubscriber/	9. E	mploye	r (con	npany)	name and a	ddress	10. Group	number
၂ င္ဂ						soc. sec. or I.	D. number	birthdate MM DD	, YYYY								
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COVERAGE	11. Is patient covered by ar	other	12-a. Na	me and addr	ress of c	arrier(s)		12-b. Gro	up no.(s)	_			13.	Name and a	ddress of	other empl	over(s)
-	derital plair.					, ,			,							·	
	yes no If yes, complete 12-a.																
5	Is patient covered by a																
N F O R M A T	plan? yes no					44 b. El	/	44 - 5	/				15	Relationship	to pation	+	
<del>^</del>	(if different than patier					14-b. Employee soc. sec.	e/subscriber or I.D. numbe	r birth	oloyee/subs idate				I _				
								MM	'	DD	'	YYY	I _		□ paren		
Ņ	-												_	· .	other_		
	ave reviewed the following t is claim. I understand that I a								authorize			ne der	ntal bei	nefits other	wise paya	ble to me	directly to the
•					Sax	MESS.		•			,.						
I '_	Signed (Patient, or parent if mi	nor)				Date			(Insured pe	erson)						Da	ate
_	16. Name of Billing Dentist								24. Is treatm		ılt No	Yes If	yes, e	nter brief de	scription a	ind dates	
B	SEE ATTACH	IED	ATTE	ENDIN	G D	ENTIS1	'S STA	ATEME	N occup	r injury?							
L	17. Address where paymen	should	be remitted	d					25. Is treatm								
									of auto a	accident's	'						
N	City, State, Zip								26. Other ac	cident?							
D																	
E	18. Dentist Soc. Sec. or T.I.N. 19. Dentist license no. 20. Dentist phone no.								27. If prosthesis, is this			(	If no, re	ason for rep	placement)	)	28. Date of prior
N									initial pla	cement	?						placement
1		Place of	treatment	: 1	23. Rad	diographs or	No Yes H	ow many?	29. Is treatm	ent for		If	f service	es already	Date	appliances	Mos. treatment
S	current series Of	fice H	treatment osp. EC	F Other	mo	dels enclosed		- · · · · · · · · · · · · · · · · · · ·	orthodor			c	ommer		place		remaining
Н	dentify missing teeth with "x"	20 Ev	amination	and traatma	nt plop	List in order fro	om tooth no. 1	through tooth	22 11	o obor	ting ov						For
			ammanom	and treatmen	ilit piali -	List in older in	Jili tootii iio. i	unough tooth	110. 32 - 08	e chai	uriy sys		IIOWII.				
		$\vdash$		Description	of servi	re				Da	te serv	ice	l p	rocedure	F	-00	administrative
	FACIAL	Tooth # or	Surface	Description (including x-		ce rophylaxis, mat	erials used, e	c.)		р	ate serv erforme	ed	1	rocedure number	F	ee	administrative use only
	FACIAL	Tooth		(including x-	k-rays, pr	rophylaxis, mat			A TEL 45	Mo.	erforme		1		F	ee	
	FACIAL	Tooth # or		(including x-	k-rays, pr				ATEME	Mo.	erforme	ed	1		F	ee	
96	FACIAL  FACIAL	Tooth # or		(including x-	k-rays, pr	rophylaxis, mat			ATEME	Mo.	erforme	ed	1		F	ee	
EUD)A	FACIAL  5 9 10 10 10 10 10 10 10 10 10 10 10 10 10	Tooth # or		(including x-	k-rays, pr	rophylaxis, mat			ATEME	Mo.	erforme	ed	1		F	ee	
(COCOCO)	FACIAL  FACIAL	Tooth # or		(including x-	k-rays, pr	rophylaxis, mat			ATEME	Mo.	erforme	ed	1		F	ee	
(A)(A)(A)(A)	FACIAL  (5) 8 9 10 11 12 12 12 13 13 13 13 13 13 13 13 13 13 13 13 13	Tooth # or		(including x-	k-rays, pr	rophylaxis, mat			ATEME	Mo.	erforme	ed	1		F	ee	
a colored	FACIAL  FACIAL	Tooth # or		(including x-	k-rays, pr	rophylaxis, mat			ATEME	Mo.	erforme	ed	1		F	ee	
and the second s	FACIAL  FACIAL	Tooth # or		(including x-	k-rays, pr	rophylaxis, mat			ATEME	Mo.	erforme	ed	1		F	ee	
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(C)(C)(C)(C)(C)(C)(C)(C)(C)(C)(C)(C)(C)(	FACIAL  FACIAL	Tooth # or		(including x-	k-rays, pr	rophylaxis, mat			ATEME	Mo.	erforme	ed	1		F	ee	
(ACC) . (DC)(A)	FACIAL  FACIAL	Tooth # or		(including x-	k-rays, pr	rophylaxis, mat			ATEME	Mo.	erforme	ed	1		F	- ee	
3.44.60.00 <b>.</b> 0.00.00.00.00.00.00.00.00.00.00.00.00.0	FACIAL  TO 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Tooth # or		(including x-	k-rays, pr	rophylaxis, mat			ATEME	Mo.	erforme	ed	1		F	- ee	
- MOM - MANNE	FACIAL  TO THE PROPERTY OF THE	Tooth # or		(including x-	k-rays, pr	rophylaxis, mat			ATEME	Mo.	erforme	ed	1		F	- ee	
AMBB BABBB	FACIAL	Tooth # or		(including x-	k-rays, pr	rophylaxis, mat			ATEME	Mo.	erforme	ed	1		F	ee	
AMBIGI . CORPRE	FACIAL  TO B 10 11  TO B 10 11  TO B F G 12  TO B LINGUAL 1 16  TO B LINGUAL 1 17  TO B LINGUAL L 19  TO B L 19	Tooth # or		(including x-	k-rays, pr	rophylaxis, mat			ATEME	Mo.	erforme	ed	1		F	ee	
ACCIDICI . COCIUS	RENT BLEFT PRESENT OF THE PRESENT OF	Tooth # or letter		(including x-	k-rays, pr	rophylaxis, mat			ATEME	Mo.	erforme	ed	1		F	ee	
31.	FACIAL  PACIAL  Remarks for unusual services	Tooth # or letter		(including x-	k-rays, pr	rophylaxis, mat			ATEME	Mo.	erforme	ed	1		F	- ee	
31.	RENT BLEFT PRESENT OF THE PRESENT OF	Tooth # or letter		(including x-	k-rays, pr	rophylaxis, mat			ATEME	Mo.	erforme	ed	1		F	- ee	
31.	RENT BLEFT PRESENT OF THE PRESENT OF	Tooth # or letter		(including x-	k-rays, pr	rophylaxis, mat			ATEME	Mo.	erforme	ed	1		F	- ee	
31.	RENT BLEFT PRESENT OF THE PRESENT OF	Tooth # or letter		(including x-	k-rays, pr	rophylaxis, mat			ATEME	Mo.	erforme	ed	1		F	- ee	
31.	RENT BLEFT PRESENT OF THE PRESENT OF	Tooth # or letter		(including x-	k-rays, pr	rophylaxis, mat			ATEME	Mo.	erforme	ed	1		F	- ee	
Ιh	FACIAL  Remarks for unusual services	Tooth # or letter	Surface	by date have	ve been	completed an	DING DEN	ITIST'S ST	ATEME	Mo.	erforme	ed	Total	Fee	F	- ee	
Ιh	REMATE BLEFT	Tooth # or letter	Surface	by date have	ve been	completed an	DING DEN	ITIST'S ST	ATEME	Mo.	erforme	ed		Fee	F	- ee	
I h	FACIAL  Remarks for unusual services at the actual fees I have charge	Tooth # or letter	indicated intend to	by date hav	ve been	completed an ocedures.	DING DEN	ITIST'S ST	ATEME	Mo.	erforme	ed	Total	Fee	F	- ee	
I h	FACIAL  Remarks for unusual services	Tooth # or letter	indicated intend to	by date have collect for the	ve been	completed an occedures.	DING DEN	ITIST'S ST	Da	P Mo.	erforme	ed	Total	Fee		- ee	
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I h are	ereby certify that the proceed en the actual fees I have charged SEE ATTACHED signed (Treating Dentist)	Tooth # or letter	indicated intend to	by date hav collect for the G DENT	ve been hose pro	completed an occedures.  S STATE Neber N	d that the fee	ITIST'S ST		P Mo.	erforme	ed	Total Charge	Fee ged  x. Allowable ductible		- ee	