

<b>HEADER INFORMATION</b>					<b>CARRIER NAME AND ADDRESS:</b>										
1. Type of Transaction (Check all applicable boxes) <input type="checkbox"/> Statement of Actual Services – OR – <input type="checkbox"/> Request for Predetermination/Preauthorization					2. DDIL-Individual P.O. Box 5402 Lisle, IL 60532 (Please use this for individual policyholders only; Payor ID: IDIND not members of a group policy.)										
<b>PRIMARY PAYER INFORMATION</b>					<b>OTHER COVERAGE</b>										
3. Name, Address, City, State, Zip Code					16. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 17-23) <input type="checkbox"/> Yes (Complete 16-23)										
<b>PRIMARY SUBSCRIBER INFORMATION</b>					17. Subscriber Name (Last, First, Middle Initial, Suffix)										
4. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code		5. Date of Birth (MM/DD/CCYY)		6. Gender <input type="checkbox"/> M <input type="checkbox"/> F	7. Subscriber Identifier (SSN or ID#)										
8. Plan/Group Number		9. Employer Name			18. Date of Birth (MM/DD/CCYY)		19. Gender <input type="checkbox"/> M <input type="checkbox"/> F	20. Subscriber Identifier (SSN or ID#)							
<b>PATIENT INFORMATION</b>					21. Plan/Group Number		22. Relationship to Primary Subscriber (Check applicable box) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other								
10. Relationship to Primary Subscriber (Check applicable box) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other			11. Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PTS		23. Other Carrier Name, Address, City, State, Zip Code										
12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code					13. Date of Birth (MM/DD/CCYY)										
14. Gender <input type="checkbox"/> M <input type="checkbox"/> F		15. Patient ID/Account # (Assigned by Dentist)													
<b>RECORD OF SERVICES PROVIDED</b>															
	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	30. Description	31. Fee						
1															
2															
3															
4															
5															
6															
7															
8															
9															
10															
<b>MISSING TEETH INFORMATION</b>		33. (Place an 'X' on each missing tooth)										31a. Other Fee(s)			
		Permanent										Primary			
		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			
		32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17										T S R Q P O N M L K			
34. Diagnosis Code List Qualifier <input type="checkbox"/> <input type="checkbox"/> (ICD-9 = B, ICD-10 = AB)					34a. Diagnosis Code(s) (Primary diagnosis in "A")					A _____ B _____ C _____ D _____					
35. Remarks															
<b>AUTHORIZATIONS</b>						<b>ANCILLARY CLAIM/TREATMENT INFORMATION</b>									
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or 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 by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.  X _____ Patient/Guardian signature Date						38. Place of Treatment (Check applicable box) <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other			39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s) _____						
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.  X _____ Subscriber signature Date						40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)			41. Date Appliance Placed (MM/DD/CCYY)						
42. Months of Treatment Remaining			43. Replacement of Prostheses? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)			44. Date Prior Placement (MM/DD/CCYY)									
45. Treatment Resulting from (Check applicable box) <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident						46. Date of Accident (MM/DD/CCYY)			47. Auto Accident State						
<b>BILLING DENTIST OR DENTAL ENTITY</b> (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)						<b>TREATING DENTIST AND TREATMENT LOCATION INFORMATION</b>									
48. Name, Address, City, State, Zip Code						53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.  X _____ Signed (Treating Dentist) Date									
49. Corporate Entity NPI (Type 2)		50. License Number		51. SSN or TIN		54. Individual NPI (Type 1)			55. License Number						
52. Phone Number ( ) -						56. Address, City, State, Zip Code			56a. Provider Specialty Code						
52a. Additional Provider ID						57. Phone Number ( ) -			58. Treating Provider Specialty						