## Monroe County Dental Assistance Plan (585) 241-9500 / (800) 666-6690, Ext. 501

ADIA. Dental	Claim	Forr	n									/		^						
HEADER INFORMAT	TION								]			A		X	١					
1 Type of Transaction (M				4	SZ Co	T,	ļ													
Statement of Actu				A.		<b>\$</b>	′													
EPSDT: Title XIX									L											
2. Predetermination/Pre	authorization	Number							-	OLICYHOLE										
									12	2. Policyholder/	/Sul	bscriber Name	(Last, Fir	rst. M	Middle Init	al. Suffix	). Addre	ess. City. Stat	e. Zip C	ode
INSURANCE COMP				AN INFO	MATION	1			1											
<ol><li>Company/Plan Name.</li></ol>	. Address, City	State. Z	(ip Code						1											
	ECONON			INC TE	PA				1											
1050 UNI ROCHES	L							1			ID (00)									
Electroni	13	B. Date of Birth	(MI	M/DD/CCYY)	14.	Gen		15. Po	ікупона	er/Subscriber	ID (55)	N or ID#)								
									+.	C. Dian (Const.)	•		1 17 5-	M		<u> </u>				
4 Other Dental or Medic		,	No (Skip	F 11	Пусс	Comp	lete 5-11)		┨"	6. Plan/Group	Nur	mber	17. 611	npio	yer Name					
						(COMp	lete 3-11)		+	ATIENT INFO	OP.	MATION	<u> </u>			····				
5 Name of Policyholder.	/Subscriber in	#4 (Last	, FIRST, MIC	idie initial, s	oumix)				-				ubscriber	ın#	12 Above			19 Stude	ent Statu	ıs
Date of Birth (MM/DD/CCYY) 7 Gender 8 Policyholder/Subscriber ID (SSN or ID#)									18 Relationship to Policyholder/Subscriber in #12 Above 19 Student Status  Self Spouse Dependent Child Other FTS PTS											PTS
6 Date of Birth (WINDD	B Policyholder/Subscriber ID (SSN or ID#)						20	) Name (Last.	Fire											
9 Plan/Group Number				tionship to	Person Na	med in	#5		1						,		,			
5 Train Group Parines.		Пse		Spouse	Dep			Other												
11 Other Insurance Com	npany/Dental								1											
									1											
	21	Date of Birth	(M	M/DD/CCYY,	22.0	Geno	der	23. Pati	ent ID//	Account # (As	signed l	by Dentist)								
														М	F					
RECORD OF SERVI	CES PROV	IDED							-											
24 Procedure Dat	24 Procedure Data 25 Area 26 27 Tooth Number(s) 28 Tooth 29 Proce								dure	I			20. 5						T	31. Fee
(MM/DD/CCYY)		Tooth System		or Letter(s)		5	iurtace	Code				30. Descrip			ription	JUON			31.	
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MISSING TEETH INF	FORMATIO	N .	2 2	4 5	6 7	Perm		11 12	12	14 15 1	-	A B C		Pome	F G	ш 1		32. Other Fee(s)		
34. (Place an 'X' on each	h missing toot	h) 1 32		29 28				22 21			-+	TSR	QF	-	0 N	M L		33 Total Fee	,	<del></del>
25 Demarks		1 32	31 30	29 20	21 20	23	24 2.5	. 22 21	20	, , , ,	<u></u>	, 3 1	<u> </u>		O N	IVI L		35 10141 1 00	1	
35. Remarks																				
AUTHORIZATIONS									ANCILLARY CLAIM/TREATMENT INFORMATION											
36. I have been informed	or all	38 Place of Treatment 39 Number of Enclosures (00 to 99)																		
charges for dental service the treating dentist or de	ces and mater	nals not p	oald by my	dental ben	efit plan, u	nless p	prohibited	by law. or	Radiograph(s) Oral triage(s) Model(s)											
such charges. To the ext	tent permitted	by law. I	consent to	o your use	and disclos				40 Is Treatment for Orthodontics?  41 Date Appliance Placed (MM/DD/CCYY)											
mornation to dairy out	pary morn don't									No (Skip	p 41	1-42) Ye	s (Comp	plete	41-42)					
XPatient/Guardian signati	4	2. Months of Tr					Prosthesi	52 44.	Date Pr	rior Placemer	nt (MM/D	D/CCYY)								
	4	Remaining		□ N			omplete 4													
37 I hereby authorize and dentist or dental entity.	direct payment	of the der	tal benefits	s otherwise p	ayable to m	e, direc	tly to the b	elow named	4	5 Treatment R	Resu	ulting from								
,									1			al illness/injury	,	Г	Auto acc	cident	Γ	Other accid	dent	
XSubscriber signature					Da	ate			46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State											
BILLING DENTIST C	OR DENTAL	ENTIT	V (Leave	hlank d der			ty is not s	ubmitting	+		_			EN	T LOCA	TION IN	FORM	ATION		
claim on behalf of the pa	domining	TREATING DENTIST AND TREATMENT LOCATION INFORMATION  53 I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple																		
48 Name Address City	, State Zip C	ode							٦,	isits) or have be	en i	completed.								
•									I.	,										
									X Signed (Treating Dentist) Date											
									5	4. NPI		***************************************			55. Li	cense Nu	ımber			
									56. Address. City. State. Zip Code Specialty Code											
49 NPI	50	License	Number		51 SSN	or Tit	4		1						Cobec	any code			*********	
									1											
52 Phone	·			52A Addit	ional				5	7 Phone					58. A	dditional				