Ą	DA Dental Cla	aim	For	n																			
HEADER INFORMATION															0								
1.	Type of Transaction (Mark a	all applica	able box	es)								CompBenefits											
	Statement of Actual Ser	rvices		Reques	t for Pre	edetermin	nation/	Preau	ıthorizati	on		benefits 550 W. Adams St. Chicago, IL 6066											
	EPSDT/Title XIX												01	ompbe	11011	ıo	Chic	cago,	IL 60661-	367	ь		
2.	Predetermination/Preautho	rization I	Number								Р	POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)											
											12	2. Policyho	lder/S	Subscriber Name	Last, First	, Middle Init	tial, Suffix),	Addres	s, City, State,	Zip C	ode		
IN	ISURANCE COMPANY/	DENTA	L BEN	EFIT PL	AN INF	ORMAT	TION				1												
3.	Company/Plan Name, Addre	ess, City,	State, Z	ip Code							1												
												B. Date of E	Birth (N	MM/DD/CCYY)	14. G	ender	15. Polic	yholde	r/Subscriber IE) (SS	N or ID)#)	
														M F									
0	THER COVERAGE										16	6. Plan/Gr	oup Ni	lumber	17. Emp	loyer Name	,						
_	Other Dental or Medical Co	verage?		No (Skip 5	5-11)		Yes (C	omple	ete 5-11)		┨¨					,							
⊢	Name of Policyholder/Subs					al Suffiv)			,		-	PATIENT INFORMATION											
J.	Traine of Folicyholder/oubs	CHDCI III	π+ (Lασι	, i iist, iviidi	ale illiae	ai, Guilia)					H-	18. Relationship to Policyholder/Subscriber in #12 Above 19. Student Status											
_	Date of Birth (MM/DD/CCY)	v)	7. Geno	lor	l e Pol	licyholdo	r/Subs	oribor	ID (SSN	or ID#)	⊣՝՝	Self		Spouse	_	dent Child	Other	,	FTS	Г	лэ Пртя	2	
6. Date of Birth (MM/DD/CC11)			Л. Степс	ΠF	8. Policyholder/Subso			0 מופפי) עו ופמייט		OI ID#)	20			First, Middle Initial									
	Dian/Curun Number				ionobin	onshin to Person Named in #5					-	J. Name (L	ası, F	rirst, iviidale iriiliai	Sullix), A	daress, City	, State, Zip	Code					
9. Plan/Group Number 10. Patient's Relationship to Person Named in #5 Self Spouse Dependent Other																							
<u> </u>			<u> </u>		Spouse		Deper			Other	4												
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code																							
											L				T		I						
											21	1. Date of I	Birth (I	MM/DD/CCYY)	22. Ge		23. Patier	nt ID/A	ccount # (Assig	gned	by Der	itist)	
L																м Ш г							
R	ECORD OF SERVICES																						
	24. Procedure Date	25. Area of Oral				umber(s)			Tooth	29. Proce					30. De	scription					31. Fe	ee.	
L	(MM/DD/CCYY)	Cavity			or Lette	er(S)		St	ırface	Code	9											_	
1																						!	
2																						!	
3																						į	
4																						į	
5																							
6																						1	
7																						1	
8																						1	
9																						:	
10																						1	
_	ISSING TEETH INFORM	//ATION		1				Perma	nent						Pri	mary			32. Other				
Г			1	2 3	4	5 6	7	8	9 10	11 12	13	14 15	16	A B C	D E	F G	н і	J	Fee(s)			į	
34	. (Place an 'X' on each miss	ing tooth	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	33.Total Fee	-		!	
35	. Remarks																			-			
	. Homano																						
_	UTHORIZATIONS										Тл	NCII I AI	DV C	LAIM/TREATN	IENT INI	ODMATI	ON						
_	6. I have been informed of th	e treatme	ent plan	and assoc	iated fee	es. Lagre	ee to be	e resp	onsible fo	or all	_	8. Place of			ILIAI 1141	OHWAII		Numb	er of Enclosure	es (00) to 99))	
	narges for dental services an e treating dentist or dental p										of	Prov	idar's	Office Hosp	tal 🗀 E(ne □ 0+	har	Radiogr	raph(s) Oral Ima	age(s)	Mod	del(s)	
sι	ich charges. To the extent pe	ermitted I	by law, I	consent to	your us	se and di					\vdash												
information to carry out payment activities in connection with this claim.																							
X													No (Skip 41-42) Yes (Complete 41-42) 42. Months of Treatment 43. Replacement of Prosthesis? 44. Date Prior Placement (MM/DD/CCYY)										
Patient/Guardian signature Date												Months Remaini	of Trea		_			ate Prid	or Placement (MM/L	DD/CC	YY)	
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named														No	Yes (Complete 4	14)						
de	entist or dental entity.										4	5. Treatme	ent Res	sulting from	_	_		_					
x											L	Occupational illness/injury Auto accident Other accident											
Sı	ubscriber signature						Date				46	46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State											
	BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting													TREATING DENTIST AND TREATMENT LOCATION INFORMATION									
claim on behalf of the patient or insured/subscriber)														that the procedure n completed.	es as indica	ated by date	are in progre	ess (for	procedures that	at requ	uire mu	Itiple	
48. Name, Address, City, State, Zip Code											7"	ionaj Ui IIdV	o neel	n completed.									
										_\	l _v												
										ŝ	Signed (Treating Dentist) Date										_		
									5	54. NPI 55. License Number													
Ī											5	56. Address, City, State, Zip Code Specialty Code											
49	49. NPI 50. License Number 51. SSN or TIN										\dashv					Shec	any Code						

58. Additional Provider ID

52A. Additional Provider ID