Preferred care

Preferred Care Gold/
GoldAnywhere

Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
   - ❏ Statement of Actual Services - **OR** -
   - ❏ Request for Predetermination/Preauthorization
   - ❏ EPSDT/Title XIX
2. Predetermination/Preauthorization Number

PAYER INFORMATION

3. Name, Address, City, State, Zip Code

   Preferred Care Gold/GoldAnywhere
   1050 University Avenue, Suite A
   Rochester, NY 14607
   Electronic Payor ID 16112

SUBSCRIBER INFORMATION

4. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

5. Date of Birth (MM/DD/CCYY)	6. Gender ❏ M ❏ F	7. Subscriber Identifier (SSN or ID#)

8. Plan/Group No.

OTHER COVERAGE

9. Other Dental or Medical Coverage?
   ❏ No (Skip 5-11) ❏ Yes (Complete 5-11)
10. Subscriber in #4 (Last, First, Middle Initial, Suffix)

11. Date of Birth (MM/DD/CCYY)	12. Gender ❏ M ❏ F	13. Subscriber Identifier (SSN or ID#)

14. Plan/Group No.	15. Relationship to Primary Subscriber in #5 (Check applicable box) ❏ Self ❏ Spouse ❏ Dependent ❏ Other

16. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

AUTHORIZATIONS

17. 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 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

18. 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

RECORD OF SERVICES PROVIDED

PATIENT: ATTACH A COPY OF YOUR BILL OR STATEMENT HERE

	19. Procedure Date (MM/DD/CCYY)	20. Area of Oral Cavity	21. Tooth System	22. Tooth Number(s) or Letter(s)	23. Tooth Surface	24. Procedure Code	25. Description	26. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

27. (Place an "X" on each missing tooth)

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

28. Other Fee(s)

29. Total Fee

30. Remarks

ANCILLARY CLAIM / TREATMENT INFORMATION

31. Place of Treatment (Check appropriate box)
❑ Provider's Office ❑ Hospital ❑ ECF ❑ Other

32. Number of Enclosures
Radiographs ______
Oral Image(s) ______
Model(s) ______

33. Is Treatment for Orthodontics
❑ No (Skip 41-42)
❑ Yes (Complete 41-42)

34. Date Appliance Placed (MM/DD/CCYY)

35. Months of Treatment Remaining

36. Replacement of Prosthesis? ❑ No ❑ Yes (Complete 44)

37. Date Prior Placement (MM/DD/CCYY)

38. Treatment Resulting from (Check appropriate box)
❑ Occupational illness/injury ❑ Auto accident
❑ Other accident

39. Date of Accident (MM/DD/CCYY)

40. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

41. 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

42. NPI

43. License Number

44. Address, City, State, Zip Code

45. Provider Specialty Code

46. Phone Number
( ) -

47. Additional Provider ID