DENTAL INSURANCE CLAIM & INVOICE

Date: _____ Invoice #: _____

BILLING DENTIST / CLINIC INFORMATION

DENTIST/CLINIC NAME

ADDRESS

PHONE NUMBER

NPI / LICENSE NO.

PATIENT INFORMATION

PATIENT FULL NAME

DATE OF BIRTH

PATIENT ID / REF NO.

ADDRESS

INSURANCE INFORMATION

INSURANCE COMPANY NAME

SUBSCRIBER NAME

RELATIONSHIP TO PATIENT

POLICY ID / MEMBER NO.

GROUP NUMBER

PRIOR AUTHORIZATION NO.

SERVICES RENDERED & DENTAL CLAIM DETAIL

Date of Svc	Tooth No.	Surface	ADA Code	Description of Service	Charge ($)

Date of Svc	Tooth No.	Surface	ADA Code	Description of Service	Charge ($)

Authorized Patient / Subscriber Signature (Assignment of Benefits)

Treating Dentist Signature & Date

Total Charges:

Insurance Contribution:

Patient Copay Paid:

Balance Due: