ADA. Dental Claim F	orm								Y - 1	-			
HEADER INFORMATION		Bahama Health											
Type of Transaction (Check all applicable boxes)						FEEL GOOD ABOUT YOUR HEALTHPLAN							
Statement of Actual Services Request for Predetermination/Preauthorization						A DIVISION OF FAMILY GUARDIAN							
EPSDT/Title XIX													
2. Predetermination/Preauthorization Number						PRIMARY INSURED INFORMATION							
						12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code							
PRIMARY PAYER INFORMATION													
3. Name, Address, City, State, Zip Code													
					1	13. Date of Birth	(MM/DD/CC	YY) 14. G	ender	15. Subscribe	r Identifier (SSN	or ID#)	
						□M □F						05,	
OTHER COVERAGE		16. Plan/Group	Number		loyer Name								
4. Other Dental or Medical Coverage?	No (Skip 5-11)	Yes (	Complete 5	i-11)									
5. Other Insured's Name (Last, First, Midd	1	PATIENT INFORMATION											
treston Attendancian A antique						18. Relationship to Primary Insured (Check applicable box)  19. Student Status							
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Subscriber Identifier (SSN or ID#)												PTS	
□M □F						20. Name (Last,							
9. Plan/Group Number 10	D. Patient's Relationship	to Other Insur	ed (Check a	applicable box	_	(====,	,	,, ר		, <u></u> p oode			
Г	Self Spous		endent	Other									
11. Other Carrier Name, Address, City, St													
					2	21. Date of Birth	(MM/DD/CC	YY) 22. Ge	ender 2	3. Patient ID//	Account # (Assig	ned by Dentist)	
							egil be	mate of	м Пғ			,,	
RECORD OF SERVICES PROVIDE	ED						1 21 71 12	J. 14 - 15 - 24 - 24 - 24 - 24 - 24 - 24 - 24 - 2					
24 Procedure Date 25. Area	26. 07 Tooth M	ımher(s)	28. Tool	th 29. Pro	codure								
(MANA/DD/CCVVV)   Of Orall I	Tooth System 27. Tooth or Lette	er(s)	Surface					30. De	scription			31. Fee	
1						HI LIN EAS		Talengalia d				1	
2							7						
3						1							
4	terin bio an	helm in circ	richart s	seeke es bass		n tai ling taris		Andrews and	is a lebes	to a color			
5						Menneral			STAL ISSUED				
6						-							
7													
8													
9												+	
10			in Secretar	in the sale	Section 1	ta display tool fire.						-	
MISSING TEETH INFORMATION			Permanent				<del></del>	D.	mary				
	1 2 3 4	5 6 7	8 9	10 11 1:	2 13	3 14 15 10	S A B	C D E	F G H	l I J	32. Other Fee(s)	1	
34. (Place an 'X' on each missing tooth)		28 27 26	25 24	23 22 2				RQP	ONN		33.Total Fee		
35. Remarks	1					7 10 10 1	1	II Q I	JO N IV	LK	33. IOIAI Fee		
AUTHORIZATIONS						ANCILLARY (	O AIRA/TES	ATMENT IN	CORMATION				
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all											her of Enclosure	s (00 to 99)	
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						38. Place of Treatment (Check applicable box)  39. Number of Enclosures (00 to 99) Radiograph(s)  Oral Image(s)  Model(s)							
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.						Provider's Office Hospital ECF Other  40. Is Treatment for Orthodontics?  41. Date Appliance Placed (MM/DD/CCYY)							
mioritation to early out payment activities	s in connection with this	Ciaiii.			-	No (Skip	_	Yes (Comple	to 41 40)	41. Date Ap	phiance Placed	(MM/DD/CCYY)	
XPatient/Guardian signature Date										44.5 5	No. 4555574		
						42. Months of Tr Remaining	eatment 43	Replacement		44. Date Pr	ior Placement (I	/IM/DD/CCYY)	
37. I hereby authorize and direct payment of the dentist or dental entity.	he dental benefits otherwis	e payable to me	, directly to the	he below name		45. Transton and D			Complete 44)				
definist of definal entity.					ľ	45. Treatment R		_	_		,		
X							onal illness/i		Auto accide		Other acciden		
						46. Date of Accid					47. Auto Accider	nt State	
BILLING DENTIST OR DENTAL EN claim on behalf of the patient or insured/su		dentist or denta	al entity is no	ot submitting	_	TREATING DI							
						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							
48. Name, Address, City, State, Zip Code						collect for those p	rocedures.				3-3-0		
						X							
						Signed (Treating Dentist) Date							
					1	54. Provider ID			55. Licen	se Number			
					_  5	56. Address, City	, State, Zip (	Code					
49. Provider ID 50. Lic	cense Number	51. SSN 6	or TIN										
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52. Phone Number ( ) -					5	57. Phone Numb	er()	_	58. Tro	eating Provide pecialty	er		

## HOW TO COMPLETE THE BAHAMAHEALTH DENTAL CLAIM FORM

Complete all areas on the claim form. Failure to do so may delay the processing of this claim.

Items 4-23 must be completed by the BahamaHealth patient.

Items 1, 2, 3 & 24-58 must be completed by the attending dentist or provider of service.

\*\*\*Claims must be submitted within six months of the date of service\*\*\*

\*\*\*Amendments should be initialed, Liquid paper will not be accepted on forms\*\*\*

Prior approval must be obtained from Bahamahealth if covered dental expenses are expected to exceed \$300.00. A pre-determination of benefit form should be forwarded to BahamaHealth in this regard.

Original receipts must be submitted. Copies will be accepted only if BahamaHealth is the secondary payer. A copy of a worksheet from the primary payer <u>must</u> accompany this form if BahamaHealth is the secondary payer.

<u>Pre-operative</u> dental x-rays must accompany all basic and major restorative claims and pre-determination of benefits requests.

With respect to accidents, please attach to the claim form, a written account of circumstances surrounding the accident.

A Police Traffic Accident Report is required for all claims relating to Auto Accidents.

Please submit claims and Pre-determination of benefits to:

BAHAMAHEALTH
Claims Department
2<sup>nd</sup> Floor, Family Guardian Financial Centre
Corner of Church and East Bay Streets
P.O. Box SS-19079
Nassau Bahamas

01/2008