1.	Dentist's pre-treatment estimate Dentist's statement of actual services	Specialty (see backside)	3. Carrier Name **Aflac New York**
2.	Medicaid Claim EPSDT	Prior Authorization #	4. Carrier Address **Claims Department • 1932 Wynnton Road**
			5. City **Columbus** 6. State **GA** 7. Zip **31999-7254**

PATIENT

8. Patient Name (Last, First, Middle)	9. Address		10. City	11. State
12. Date of Birth (MM/DD/YYYY) ___/___/___	13. Patient ID # / SSN #	14. Sex M F	15. Phone Number ( )	16. Zip Code
17. Relationship to Subscriber / Employee: Self Spouse Child Other _____		18. Employer / School Name: _____ Address: _____		

SUBSCRIBER / EMPLOYEE

19. Subs. SSN #	20. Employer Name	21. Policy #	
22. Subscriber/Employee Name (Last, First, Middle)			
23. Address	24. Phone Number ( )		
25. City	26. State	27. Zip Code	
28. Date of Birth (MM/DD/YYYY) ___/___/___	29. Marital Status Married Single Other	30. Sex M F	

39. 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 benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges.

X _____
Signed (Patient/Guardian) Date: (MM/DD/YYYY)

OTHER POLICIES

31. Is patient covered by another plan No (Skip 32-37) Yes Dental or Medical		32. Policy #
33. Other Subscriber's Name		
34. Date of Birth (MM/DD/YYYY) ___/___/___	35. Sex M F	36. Plan/Program Name
37. Employer / School Name:	Address	
38. Subscriber/Employee Status Employed Part-time Status Full-time Student Part-time Student		
40. Employer/School Name	Address	

41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

X _____
Signed (Employee/ Subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity	43. Phone Number ( )	44. Provider ID #	45. Dentist Soc. Sec. or T.I.N.
46. Address	47. Dentist License #	48. First visit date of current series:	49. Place of treatment Office Hosp. ECF Other
50. City 51. State 52. Zip Code	53. Radiographs or models enclosed? Yes, How many?_____ No	54. Is treatment for orthodontics? Yes No If service already commenced:	
55. If prosthesis (crown, bridge, dentures), is this initial placement? Yes No	If no, reason for replacement:	Date of prior placement:	Date appliances placed _____ Total months of treatment remaining: _____
56. Is treatment result of occupational illness or injury? No Yes Brief description and dates:		57. Is treatment result of: Auto Accident? Other Accident? Neither Brief description and dates:	

58. Diagnosis Code Index (optional)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____

59. Examination and treatment plans. List teeth in order.

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee

Admin. Use Only

60. Identify all missing teeth with X

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	Total Fee					
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	Payment by other plan					
				Max. allowable					
				Deductible					
				Carrier %					
				Carrier pays					
				Patient pays					

61. Remarks for unusual services:

62. 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) License # Date (MM/DD/YYYY)

63. Address where treatment was performed.

64. City	65. State	66. Zip Code

NYHF004