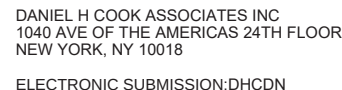


HEADER INFORMATION		
1. Type of Transaction (Check all applicable boxes)		
☐ Statement of Actual Services	☐ Request for Predetermination/Preauthorization	
☐ EPSDT/Title XIX		
2. Predetermination/Preauthorization Number		
PRIMARY PAYER INFORMATION		
3. Name, Address, City, State, ZIP Code		
DANIEL H COOK ASSOCIATES INC HARRISON CSEA 1040 AVE OF THE AMERICAS 24TH FLOOR NEW YORK, NY 10018		
OTHER COVERAGE		
4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)		
5. Other Insured's Name (Last, First, Middle Initial, Suffix)		
6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F ☐ U	8. Subscriber Identifier
9. Plan/Group Number	10. Patient's Relationship to Other Insured ☐ Self ☐ Spouse ☐ Dependent ☐ Other	
11. Other Carrier Name, Address, City, State, ZIP Code		



PRIMARY INSURED INFORMATION		
12. Name (Last, First, Middle Initial, Suffix) Address, City, State, ZIP Code		
13. Date of Birth (MM/DD/CCYY)	14. Gender ☐ M ☐ F ☐ U	15. Subscriber Identifier
16. Plan/Group Number	17. Employer Name	
PATIENT INFORMATION		
18. Patient's Relationship to Other Insured ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other		19. Student Status ☐ FTS ☐ PTS
20. Name (Last, First, Middle Initial, Suffix) Address, City, State, ZIP Code		
21. Date of Birth (MM/DD/CCYY)	22. Gender ☐ M ☐ F ☐ U	23. Patient ID/Account # (Assigned by Dentist)

[illegible]

33. Missing Teeth Information (Place an "X" on each missing tooth.)																34. Diagnosis Code List Qualifier ☐ ☐ (ICD-9 = B; ICD-10 = AB)										31a.	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	34a. Diagnosis Code(s) A _____ C _____										Other Fee(s)	
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	(Primary diagnosis in "A") B _____ D _____										32. Total Fee	
35. Remarks																											

AUTHORIZATIONS			ANCILLARY CLAIM/TREATMENT INFORMATION		
36. I have been informed of the treatment plan and any associated fees. I agree to be responsible for all 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 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			38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")		39. Enclosures (Y or N) ☐
			40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)	41. Date Appliance Placed (MM/DD/CCYY)	
37. 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			42. Months of Treatment Remaining	43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)	
			44. Date Prior Placement (MM/DD/CCYY)		
			45. Treatment Resulting from (Check applicable box) ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident		
			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 claim on behalf of the patient or insured/subscriber.)					
48. Name, Address, City, State, ZIP Code 					
49. NPI (Billing Entity)	50. License Number	51. SSN or TIN			
52. Phone Number () - -			TREATING DENTIST AND TREATMENT LOCATION INFORMATION		
			53. Treatment completed - payment requested. I hereby certify that I have completed the procedures as indicated by date of service. I request payment in accordance with Plan rules and regulations. X _____ Signed (Treating Dentist) Date		
			54. NPI (Treating Dentist)	55. License Number	
56. Address, City, State, ZIP Code 					
57. Phone Number () - -			58. Treating Provider Specialty		

(ADA 11/20)