ADA Dental Clai	Insured and/or Administered by Connecticut General Life Insurance Company								X	14											
HEADER INFORMATION	-																				
Type of Transaction (Mark all a	1	CIGNA Dental								NA D	ental										
Statement of Actual Service EPSDT / Title XIX	ces		Request 1	for Pre	determin	nation /	Preauthoriz	zation		For mailing address, call Customer Service at 1-800-244-622										1-6224	
2. Predetermination/Preauthoriza	ation No	ımher		_						POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)											
2. 1 reducient militarion in reduction 20	12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																				
INSURANCE COMPANY/DE	1																				
3. Company/Plan Name, Address,	1																				
				1																	
	1																				
	13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscriber ID (SSN									SN or II	D#)										
OTHER COVERAGE	1			0500	and the last of th	No.			Marie Line	16	MF 16. Plan/Group Number 17. Employer Name										
OTHER COVERAGE 4. Other Dental or Medical Covera	age?	Пио	(Skip 5-1	11)	П	Yes (C	omplete 5-	.11)		1"	. Plan/Group	INC	mber	17. Emplo	yei ivaine						
Name of Policyholder/Subscribe	PATIENT INFORMATION										-										
											18. Relationship to Policyholder/Subscriber in #12 Above 19. Student Status										
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN or ID#)										Self Spouse Dependent Child Other FTS PTS										rs	
MF									20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code												
9. Plan/Group Number 10. Patient's Relationship to Person Named in #5 Self Spouse Dependent Other																					
	-																				
11. Other Insurance Company/Den																					
											Date of Righ	- (M	IM/DD/CCYY)	22. Gend	ter 2	3 Patient II	D/Account # (As	signer	hv Der	ntist)	
										21.	. Date of Birds	, (141	INVIDENCE I I J	Пм		o. r adonen	DINGOODIN # (No	olgi icc	oy Dei	idotj	
RECORD OF SERVICES PRO	OVIDI	ED	MONOR NO THE TREE							_		-									
24 Procedure Date 25.	Area	26.	27. Too	th Num	ber(s)	Т	28. Tooth	1 29	9. Proced	lure								T			
(MANADD/CC/CV)	Oral 7 avity S			or Letter(s)			Surface		Code					30. Description						ee	
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8	\neg					\top		\top										\top		;	
9																					
10														no management of the							
MISSING TEETH INFORMATI	ION						ermanent					1		Primar			32. Other Fee(s)				
34. (Place an 'X' on each missing to	ooth)	1 2	3 4		6			10 11				-+	A B C	D E F	G H		33.Total Fee	上			
35, Remarks		32 31	30 2	9 28	21	26 2	5 24 2	23 22	21 2	20	19 18 17	_	1 3 K	u r j	J 14 1VI	LK	33.10tal 1 et				
35. Remarks															4						
AUTHORIZATIONS	AN	ICILLARY (CL	AIM/TREATM	ENT INFO	RMATION		Anti-Aldaham Arab	X-1												
36. I have been informed of the treat									, or	38.	38. Place of Treatment 39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)										
charges for dental services and mate the treating dentist or dental practice such charges. To the extent permitte	e has a	contractu	al agreen	nent wi	th my pl	an pro	hibiting all	or a por	rtion of		Provider's Office Hospital ECF Other										
information to carry out payment act	tivities i	in connect	ion with the	his clai	m.	03010	or my prote	otod Ho	Juli	40.	40. Is Treatment for Orthodontics? 41. Date Appliance Placed (MM/DD/CCYY)										
X										No (Skip 41-42) Yes (Complete 41-42)											
Patient/Guardian signature Date											42. Months of Treatment 43. Replacement of Prosthesis? 44. Date Prior Placement (MM/DD/CCYY) No Yes (Complete 44)										
37.1 hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.										45	Treatment Re	esul		les (Cui	Tiprete 44)				-	-	
											Occupational illness/injury Auto accident Other accident										
Subscriber signature Date											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											TREATING DENTIST AND TREATMENT LOCATION INFORMATION										
laim on behalf of the patient or insured/subscriber)											53. I hereby certify that the procedures as indicated by date are in progress (for procedures that requivisits) or have been completed.								quire m	ultiple	
48. Name, Address, City, State, Zip C	Code																				
·										X									_ [
										Signed (Treating Dentist) Date								-			
										54.		C+	ate, Zip Code		56A. Prov	e Number rider				-	
19. NPI 50	in Lice	nse Numb	ner		51.59	N or T	'IN			50.7	nduress, City,	, 00	ate, Zip Code		Specialty	Code				-1	
49. NPI 50. License Number 51. SSN or TIN																					
52. Phone Number ()			52A.	Addition Provide	nal er ID					57. F	Phone Number ()		58. Addition	onal ler ID					

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