CHECK ONE:
FOR PAYMENT ☐
FOR PRE-CERTIFICATION ☐

BlueCross BlueShield of Wyoming

1900 House Ave.
P.O. Box 2266
Cheyenne, Wyoming 82003-2266
Phone 307/634-1393

DENTAL SERVICE REPORT

SUBSCRIBER INFORMATION

1. PATIENT NAME
2. RELATIONSHIP TO EMPLOYEE — SELF | SPOUSE | CHILD | OTHER
3. SEX — M | F
4. PATIENT BIRTHDATE — MO. | DAY | YEAR
5. IF FULL TIME STUDENT — SCHOOL | CITY
6. EMPLOYEE/SUBSCRIBER NAME — FIRST | INITIAL | LAST
7. EMPLOYER/SUBSCRIBER - SERIES/AGREEMENT NUMBERS
8. MAILING ADDRESS, STREET, CITY, STATE, ZIP CODE
9-12. EMPLOYEE/SUBSCRIBER GROUP NO. AND/OR GROUP NAME
13. ARE OTHER FAMILY MEMBERS EMPLOYED? EMPLOYEE NAME | SOC. SEC. NO.
14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13
15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? | DENTAL PLAN NAME | UNION LOCAL | GROUP NO. | NAME AND ADDRESS OF CARRIER

PATIENTS AUTHORIZATION: I HEREBY ACCEPT THE FOLLOWING TREATMENT PLAN AND AUTHORIZE THE RELEASE OF ANY INFORMATION RELATIVE TO THIS CASE.

SIGNED (PATIENT, OR PARENT IF MINOR) | DATE

INDENTIST INFORMATION

16. DOCTOR NAME:
17. PROVIDER NUMBER
18. MAILING ADDRESS, STREET, CITY, STATE, ZIP CODE
19. DENTIST SOC. SEC. OR T.I.N.
20. DENTIST LICENSE NO.
21. DENTIST PHONE NO.
22. FIRST VISIT DATE CURRENT SERIES
23. PLACE OF TREATMENT — OFFICE | HOSP. | ECF | OTHER
24. RADIOGRAPHS OR MODELS ENCLOSED — NO | YES | HOW MANY?

	NO	YES	
25. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			IF YES, ENTER BRIEF DESCRIPTION AND DATES
26. IS TREATMENT RESULT OF AUTO ACCIDENT?			
27. OTHER ACCIDENT?			
28. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
29. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) — 30. DATE OF PRIOR PLACEMENT
31. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED, ENTER — DATE APPLIANCES PLACED — MOS. TREATMENT REMAINING

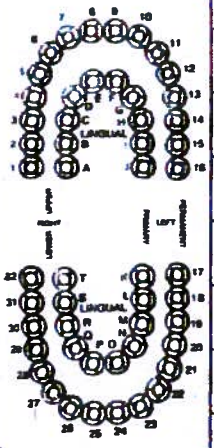
DENTISTS STATEMENT: I HEREBY CERTIFY THAT THE SERVICES LISTED HAVE BEEN OR WILL BE PROVIDED BY ME.

DENTIST'S SIGNATURE | DATE

32. EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 - USE CHARTING SYSTEM SHOWN.

IDENTIFY MISSING TEETH WITH "X"

FACIAL



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TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO.	DAY	YEAR	PROCEDURE NUMBER	FEE
						TOTAL FEE ACTUALLY CHARGED	