

Accident Form for Dental Injury

Arkansas Blue Cross and Blue Shield
BlueAdvantage and Health Advantage
601 Gaines
Little Rock, AR 72201

Patient's Name: _____

Date of Accident: _____

Identification Number: _____

ICN: _____

Dear Doctor:

We are seeking information regarding the dental services provided by you for the above named patient. The Surgical-Medical Policy this patient has with Blue Cross and Blue Shield, BlueAdvantage, or Health Advantage provides coverage for dental treatment only in case of accidental injury and accident-related damage to teeth, and then as a rule only to sound natural teeth. A sound natural tooth is a tooth that is whole, free of any restorations, periodontal disease or other conditions, and is not in need of treatment for any reason other than accidental injury.

DIAGNOSTIC X-RAYS AND THIS COMPLETED FORM ARE REQUIRED TO DETERMINE A CONSIDERATION OF PAYMENT. Please review your records and respond to the following questions. Thank you for your assistance in this matter.

1. Give a brief description of the accident: _____

2. Were you the first doctor to see the patient? Yes _____ No _____
If answer is NO, or if another person is involved in the treatment of the patient, please list:
Hospital Emergency Room: _____
Other Doctor: _____

3. Indicate your findings at the initial examination. Please be specific as to tooth number and actual damage.

Tooth	Nature of Damage	Pre-existing Conditions (include restorations)

Other general findings: _____

4. List all treatment rendered as a result of this accident

Date	Tooth	Service	Dental Code	Fee

Other treatment to follow: _____

Doctor's Signature

Date