Accident Form for Dental Injury

Patient Information

Patient's name	Identification number of plan participant

Date of accident	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 tosound 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.

Give a brief description of the accident

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

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

List all treatment rendered as a result of this accident

Date	Tooth	Service	Dental Code	Fee

Other treatment to follow

Doctor's signature

Date signed (mm/dd/yyyy)