Accident Form for Dental Injury

BlueAdvantage Administrators of Arkansas

An Independent Licensee of the BlueCross and BlueShield Association

601 S. Gaines Street, Little Rock, AR 72201

Patient's Name: _____

Date of Accident: _____

Medical 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 BlueAdvantage Administrators of Arkansas or is administered by BlueAdvantage Administrators of Arkansas 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 decay, 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: _____

_____

_____

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

Date	Tooth	Service	Dental Code	Fee

Other treatment to follow: _____

_____

_____

_____

_____ _____

Doctor's Signature Date

_____

Doctor's Printed Name

_____

Street Address

_____

City, State, Zip

_____

Phone Number (including area code)

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