Medical/Dental Insurance Case Submission Form

FAX submission form to (315) 875-9200

Patient Last Name, First Initial	Last:_____ First:_____	Relationship to Insured	___self ___child ___spouse	Patient's Date of Birth_____
Medical Insurance Name: _____ Medical Insurance ID#_____Group#_____ Address to file claims:_____ _____		Subscriber Full Name and Date of Birth	Last Name:_____ First Name:_____ Date of Brith:_____ Relationship to patient:___self___child___spouse	
Medical Insurance ID#		Group #		
Dental Insurance Name: _____ Dental Insurance ID#_____Group#_____ Address to file claims:_____ _____		Subscriber Full Name and Date of Birth	Last Name:_____ First Name:_____ Date of Brith:_____ Relationship to patient:___self___child___spouse	
Dental Insurance ID#		Group #		
Name on Credit Card		I authorize Dental Claims Cleanup Cleanup to charge my card $_____	_____Signature	
Credit card #		Expiration Date	_____CVV code_____	

Planned Procedures	Completed Procedures	Provider Notes
1. _____$_____ 2._____$_____ 3._____ $_____ 4._____$_____ 5._____ $_____ 6._____$_____	1. _____Consult _____Exam Date_____$_____ 2._____Date_____$_____ 3._____Date_____$_____ 4._____Date_____$_____ 5._____Date_____$_____ 6._____Date_____$_____	
Diagnoses (descriptions) 1. 2. 3. 4. 5.	Diagnoses (descriptions) 1. 2. 3. 4. 5.	
Contributing medical history (ie. co-morbidities, trauma, etc.) : 1.	Contributing medical history (ie. co-morbidities, trauma, etc.) : 1.	

2. 3.	2. 3.	

Treating Provider Name_____Address_____

Specialty of Provider_____TaxID#_____

Provider NPI#_____Phone #_____

I certify that the information I am submitting to Dental Claims Cleanup is authentic and accurate and reflects treatment rendered by the provider for the patient listed above. I also grant Dental Claims Cleanup authorization to contact the provider that is listed to have rendered treatment to verify all information submitted. I understand the HIPAA patient privacy policies. Dental Claims Cleanup will not share or disclose and patient information with any other party other than the provider, insurance companies listed in this document, and the patient or patient's guardian as it pertains to the billing of medical/dental insurances for services rendered. The fax number listed is a confidential dedicated fax number that is only used by authorized persons.

Patient/Guardian Signature_____Date_____

Provider Signature_____Date_____(or a receipt/bill, we will verify the information with the provider)

Submitted to DCC Date_____

Dental Claims Cleanup
3649 Erie Blvd East, Unit 10
Dewitt, NY 13214
800-652-3431
www.dentalclaimscleanup.com
contact@dentalclaimscleanup.com
FAX medical claim form submission to (315) 875-9200 and/or telemedicine bill/receipt. Each claim submitted is $10 and each preauthorization is $5.