# Accident Form for Dental Injury

**Health Advantage**

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 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 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: _____

_____

_____

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

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| 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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