ADA Dental Claim Form

APPROVED 8/25/16

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
[X] Statement of Actual Services [ ] Request for Predetermination/Preauthorization [ ] EPSDT/Title XIX

2. Predetermination/Preauthorization Number

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code
Cochise County Health Department
1415 Melody Lane
BLDG A
BISBEE, AZ 85603

OTHER COVERAGE

4. Other Dental or Medical Coverage? [X] No (Skip 5-11) [ ] Yes (Complete 5-11)

5. Other Insured's Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender [ ] M [ ] F | 8. Subscriber Identifier (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Other Insured (Check applicable box) [ ] Self [ ] Spouse [ ] Dependent [ ] Other

11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY INSURED INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]
Cochise County
BISBEE, AZ 85603

13. Date of Birth (MM/DD/CCYY): 10/12/1970 | 14. Gender [X] M [ ] F | 15. Subscriber Identifier (SSN or ID#)

16. Plan/Group Number | 17. Employer Name: Cochise County Corrections

PATIENT INFORMATION

18. Relationship to Primary Insured (Check applicable box) [X] Self [ ] Spouse [ ] Dependent Child [ ] Other | 19. Student Status [ ] FTS [ ] PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]
Cochise County
BISBEE, AZ 85603

21. Date of Birth (MM/DD/CCYY): 10/12/1970 | 22. Gender [X] M [ ] F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	04/30/2015		JP	10		D0230	INTRAORAL-PERIAPICAL-EACH ADDITIONAL FIL	16.00
2	04/30/2015		JP	13		D0230	INTRAORAL-PERIAPICAL-EACH ADDITIONAL FIL	16.00
3	04/30/2015		JP	4		D0220	INTRAORAL-PERIAPICAL FIRST FILM	19.00
4	04/30/2015		JP	7		D0230	INTRAORAL-PERIAPICAL-EACH ADDITIONAL FIL	16.00
5	04/30/2015		JP	2		D7210	SURGICAL REMOVAL OF ERUPTED TOOTH	130.00
6	04/30/2015		JP	15		D7210	SURGICAL REMOVAL OF ERUPTED TOOTH	130.00
7	04/30/2015		JP	13		D7210	SURGICAL REMOVAL OF ERUPTED TOOTH	130.00
8	04/30/2015		JP	12		D7210	SURGICAL REMOVAL OF ERUPTED TOOTH	130.00
9	04/30/2015		JP	11		D7210	SURGICAL REMOVAL OF ERUPTED TOOTH	130.00
10	04/30/2015		JP	10		D7210	SURGICAL REMOVAL OF ERUPTED TOOTH	130.00

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent															
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Primary										
A	B	C	D	E	F	G	H	I	J	
T	S	R	Q	P	O	N	M	L	K	

32. Other Fee(s)

33. Total Fee

35. Remarks: Adjusted Claim Form 100.50005720 43k.334

Continued

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X [redacted] Patient/Guardian signature: Signature on File Date: 04/14/2016

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below-named dentist or dental entity.

X [redacted] Subscriber signature: Signature on File Date: 04/14/2016

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code
Jerrod D. Long, DDS
P.O. BOX 1898
BISBEE, AZ 85603

49. Provider ID	50. License Number	51. SSN or TIN
1356493829	AZ D 5037	20-8157488

52. Phone Number: (520) 432-5371

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box) [X] Provider's Office [ ] Hospital [ ] ECF [ ] Other

39. Number of Enclosures (00 to 99): Radiograph(s) | Oral Image(s) | Model(s)

40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? [ ] No [ ] Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box) [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X [redacted] Signed (Treating Dentist) Date: 04/14/2016

54. Provider ID	55. License Number
1356493829	AZ D 5037

56. Address, City, State, Zip Code
P.O. BOX 1898
BISBEE, AZ 85603

57. Phone Number: (520) 432-5371

58. Treating Provider Specialty: 1223G0001X

NEGOTIATE

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
[X] Statement of Actual Services [ ] Request for Predetermination / Preauthorization
[ ] EPSDT/Title XIX

2. Predetermination/Preauthorization Number

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code
Cochise County Health Department
1415 Melody Lane
BLDG A
BISBEE, AZ 85603

OTHER COVERAGE

4. Other Dental or Medical Coverage? [X] No (Skip 5-11) [ ] Yes (Complete 5-11)

5. Other Insured's Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender [ ] M [ ] F | 8. Subscriber Identifier (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Other Insured (Check applicable box) [ ] Self [ ] Spouse [ ] Dependent [ ] Other

11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY INSURED INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]
Cochise County
BISBEE, AZ 85603

13. Date of Birth (MM/DD/CCYY) 10/12/1970 | 14. Gender [X] M [ ] F | 15. Subscriber Identifier (SSN or ID#)

16. Plan/Group Number | 17. Employer Name: Cochise County Corrections

PATIENT INFORMATION

18. Relationship to Primary Insured (Check applicable box) [X] Self [ ] Spouse [ ] Dependent Child [ ] Other | 19. Student Status [ ] FTS [ ] PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]
Cochise County
BISBEE, AZ 85603

21. Date of Birth (MM/DD/CCYY) 10/12/1970 | 22. Gender [X] M [ ] F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	04/30/2015		JP	9		D7210	SURGICAL REMOVAL OF ERUPTED TOOTH	130.00
2	04/30/2015		JP	8		D7210	SURGICAL REMOVAL OF ERUPTED TOOTH	130.00
3	04/30/2015		JP	7		D7210	SURGICAL REMOVAL OF ERUPTED TOOTH	130.00
4	04/30/2015		JP	6		D7210	SURGICAL REMOVAL OF ERUPTED TOOTH	130.00
5	04/30/2015		JP	5		D7210	SURGICAL REMOVAL OF ERUPTED TOOTH	130.00
6	04/30/2015		JP	4		D7210	SURGICAL REMOVAL OF ERUPTED TOOTH	130.00
7	04/30/2015		JP	3		D7210	SURGICAL REMOVAL OF ERUPTED TOOTH	130.00
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent															
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Primary									
A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s): 0.00
33. Total Fee: 1,757.00

35. Remarks
$ 1757.00

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X [redacted] Patient/Guardian signature — Signature on File — Date 04/14/2016

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X [redacted] Subscriber signature — Signature on File — Date 04/14/2016

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code
Jerrod D. Long, DDS
P.O. BOX 1898
BISBEE, AZ 85603

49. Provider ID	50. License Number	51. SSN or TIN
1356493829	AZ D 5037	20-8157488

52. Phone Number (520) 432-5371

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box) [X] Provider's Office [ ] Hospital [ ] ECF [ ] Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? [ ] No [ ] Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box) [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X [redacted] Signed (Treating Dentist) — Date 04/14/2016

54. Provider ID	55. License Number
1356493829	AZ D 5037

56. Address, City, State, Zip Code
P.O. BOX 1898
BISBEE, AZ 85603

57. Phone Number (520) 432-5371

58. Treating Provider Specialty 1223G0001X

ADA Dental Claim Form

ORIGINAL AMT INVOICED #2927.00 TIMELY SUBMITTED

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
[X] Statement of Actual Services [ ] Request for Predetermination/Preauthorization
[ ] EPSDT/Title XIX

2. Predetermination/Preauthorization Number

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code
Cochise County Health Department
1415 Melody Lane
BLDG A
BISBEE, AZ 85603

OTHER COVERAGE

4. Other Dental or Medical Coverage? [X] No (Skip 5-11) [ ] Yes (Complete 5-11)

5. Other Insured's Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender [ ] M [ ] F | 8. Subscriber Identifier (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Other Insured (Check applicable box) [ ] Self [ ] Spouse [ ] Dependent [ ] Other

11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY INSURED INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]
Cochise County
BISBEE, AZ 85603

13. Date of Birth (MM/DD/CCYY): 10/12/1970 | 14. Gender [X] M [ ] F | 15. Subscriber Identifier (SSN or ID#)

16. Plan/Group Number | 17. Employer Name: Cochise County Corrections

PATIENT INFORMATION

18. Relationship to Primary Insured (Check applicable box) [X] Self [ ] Spouse [ ] Dependent Child [ ] Other | 19. Student Status [ ] FTS [ ] PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]
Cochise County
BISBEE, AZ 85603

21. Date of Birth (MM/DD/CCYY): 10/12/1970 | 22. Gender [X] M [ ] F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	04/30/2015		JP	10		D0230	INTRAORAL-PERIAPICAL-EACH ADDITIONAL FIL	16.00
2	04/30/2015		JP	13		D0230	INTRAORAL-PERIAPICAL-EACH ADDITIONAL FIL	16.00
3	04/30/2015		JP	4		D0220	INTRAORAL-PERIAPICAL FIRST FILM	19.00
4	04/30/2015		JP	7		D0230	INTRAORAL-PERIAPICAL-EACH ADDITIONAL FIL	16.00
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9	04/30/2015		JP	7		D7210	SURGICAL REMOVAL OF ERUPTED TOOTH	220.00
10	04/30/2015		JP	8		D7210	SURGICAL REMOVAL OF ERUPTED TOOTH	220.00

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	
	X	X	X	X	X	X	X	X	X	X	X	X		X													

35. Remarks

Continued

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X [redacted] Signature on File 05/04/2016
Parent/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X [redacted] Signature on File 05/04/2016
Subscriber signature Date

Original

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code
Jerrod D. Long, DDS
P.O. BOX 1898
BISBEE, AZ 85603

49. Provider ID: 1356493829 | 50. License Number: AZ D 5037 | 51. SSN or TIN: 20-8157488

52. Phone Number: (520) 432-5371

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box) [X] Provider's Office [ ] Hospital [ ] ECF [ ] Other

39. Number of Enclosures (00 to 99) Radiograph(s) | Oral Image(s) | Model(s)

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41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? [ ] No [ ] Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box) [ ] Occupational Illness/Injury [ ] Auto accident [ ] Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X Jerrod Long 05/04/2016
Signed (Treating Dentist) Date

54. Provider ID: 1356493829 | 55. License Number: AZ D 5037

56. Address, City, State, Zip Code
P.O. BOX 1898
BISBEE, AZ 85603

57. Phone Number: (520) 432-5371 | 58. Treating Provider Specialty: 1223G0001X

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
[X] Statement of Actual Services [ ] Request for Predetermination/Preauthorization
[ ] EPSDT/Title XIX

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1415 Melody Lane
BLDG A
BISBEE, AZ 85603

OTHER COVERAGE

4. Other Dental or Medical Coverage? [X] No (Skip 5-11) [ ] Yes (Complete 5-11)

5. Other Insured's Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender [ ] M [ ] F | 8. Subscriber Identifier (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Other Insured (Check applicable box) [ ] Self [ ] Spouse [ ] Dependent [ ] Other

11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY INSURED INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
[redacted]
Cochise County
BISBEE, AZ 85603

13. Date of Birth (MM/DD/CCYY) 10/12/1970 | 14. Gender [X] M [ ] F | 15. Subscriber Identifier (SSN or ID#)

16. Plan/Group Number | 17. Employer Name: Cochise County Corrections

PATIENT INFORMATION

18. Relationship to Primary Insured (Check applicable box) [X] Self [ ] Spouse [ ] Dependent Child [ ] Other | 19. Student Status [ ] FTS [ ] PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
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Cochise County
BISBEE, AZ 85603

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7	04/30/2015		IP	2		D7210	SURGICAL REMOVAL OF ERUPTED TOOTH	220.00
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K
		X	X	X	X	X	X	X	X	X	X	X		X											

32. Other Fee(s) 0.00
33. Total Fee 3,927.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X [redacted] Signature on File 05/04/2016
Patient/Subscriber Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

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41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? [ ] No [ ] Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box) [ ] Occupational Illness/Injury [ ] Auto accident [ ] Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

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X Jerrod Long 05/04/2016
Signed (Treating Dentist) Date

54. Provider ID 1356493829 | 55. License Number AZ D 5037

56. Address, City, State, Zip Code
P.O. BOX 1898
BISBEE, AZ 85603

57. Phone Number (520) 432-5371 | 58. Treating Provider Specialty 1223G0001X

Ship To
Cochise County Health Department
1415 Melody Lane, Building A
BISBEE, AZ 85603

Bill To
Cochise County Health Department
1415 Melody Lane, Building A
BISBEE, AZ 85603

Purchase Order
No. 2016-00000146

DATE 07/23/2015

Reprint Purchase Order

VENDOR 21108 - Long, Jerrod D. DDS

Vendor
Long, Jerrod D. DDS
PO Box 1898, 2 Naco Road
BISBEE, AZ 85603

PURCHASE ORDER NUMBER MUST APPEAR ON ALL INVOICES, SHIPPERS, BILL OF LADING AND CORRESPONDENCE

DELIVER BY
SHIP VIA
FREIGHT TERMS
PAGE **1 of 1**
BUYER: Terry Rutan

REFERENCE # Cochise County #15-21-HEA-03

QUANTITY	UNIT	DESCRIPTION	STATUS	UNIT COST	TOTAL COST
1.0000	Each	Dental Dental services for inmates - covers period 7/1/15 to 6/30/16. 100-5000-5220 431.336 - Dental 9,000.00 4-30-15 [redacted] $1,757.00 NEGOTIATED Prices!	Open	9,000.0000	$9,000.00
				TOTAL DUE	$9,000.00

PURCHASING AUTHORIZED REPRESENTATIVE

520-432-8390

Special Instructions

RECEIVING REPORT
SIGNED: L. Grunwood
DATE: 5-05-16

1. Direct inquires pertaining to this order to the purchasing authorized representative.
2. Cochise County is subject to Arizona State and Local sales tax. Invoices should reflect the appropriate tax.
3. Effective July 1, 1979, all county and municipal governments are to be registered to report and pay the Arizona Use Tax, at the rate of 5.6%, directly to the Arizona Department of revenues on purchases of tangible property from out-of-state vendors. Do not add such tax on any billing or invoice.
4. Purchases made by Cochise County are exempt from Federal excise taxes.
5. Reference the Purchase Order number on all invoices.
6. For Terms and Conditions -- See www.cochise.az.gov/departments/procurement.