

SMART DATA STREAM COMPANION GUIDE

[PORTAL.SMARTDATASTREAM.US](https://portal.smartdatastream.us)

SDS Provider Support

stream.support@sdata.us

855-297-4436

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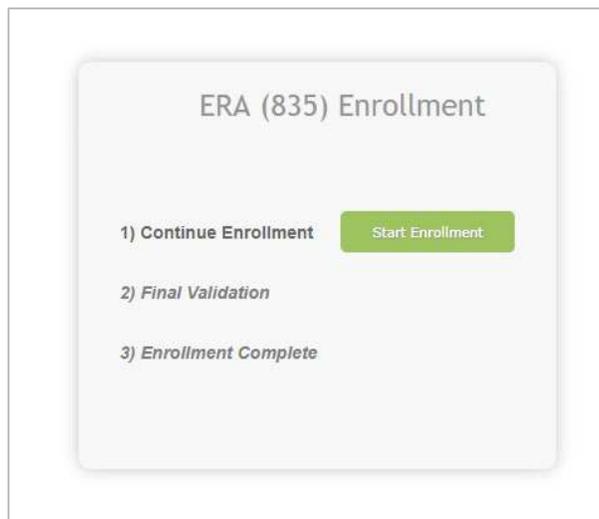
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ERA ENROLLMENT

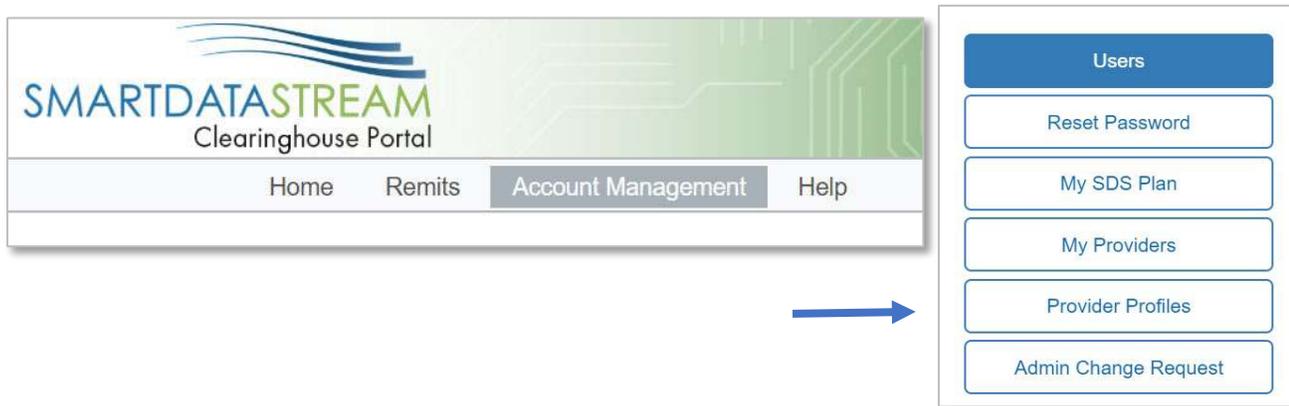
- There are several different methods for starting an ERA account with Smart Data Solutions depending on which payer you're enrolling for. If you have an account that doesn't include ERA enrollment already, or if you have a specific ERA account and would like access to additional payer's ERAs, please contact us as stream.support@sdata.us or 855-297-4436 opt. 2 for more information.

STARTING ERA ENROLLMENT

- After you've logged in and changed your password, you should be immediately prompted to start your ERA enrollment.

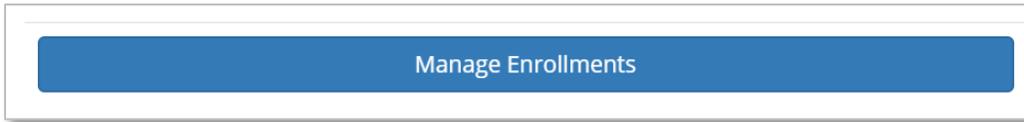


- If the above screen does not automatically appear you can select Account Management at the top bar. Then select Provider Profiles



OR

- Select Remits at the top bar then Manage Enrollments



ENROLLMENT FORM

Profile

Profile Nickname

Provider Information

* Name
Test Provider T1000

Doing Business As (DBA)

* Address Line 1

Address Line 2

Provider Identifiers Information

* Tax Identification Number (TIN) * Verify TIN:

National Provider Identifier (NPI) Verify NPI

Trading Partner ID

Provider Contact Information

* Last Name * First Name

test test

* Contact Phone

(651) 555-5555 x55555

Contact Fax

Profile Name will not affect your ERAs and is only for labeling enrollments on your account

Don't forget to verify your tax ID

NPI is not required for your ERA enrollment. If left blank, you will receive ERAs for all NPIs associated with the Tax ID you enroll

Trading Partner ID is not required if you do not have one

Fax may be left blank if unavailable

- Under Payer Selection select "or select individual payers" You will then see the screen below:

Select Payers x

Click on the following alphabets to search by payer name.

Show entries Search:

Select Payer	Payer Name	Payer ID
3		
<input type="checkbox"/>	3P ADMIN	20413
A		
<input checked="" type="checkbox"/>	All Payers	ALL
<input type="checkbox"/>	ACTIVA BENEFIT SERVICES LLC	38254
<input type="checkbox"/>	Administrative Concepts, Inc	22384
<input type="checkbox"/>	American Family Insurance	56071
<input type="checkbox"/>	AMERICAN REPUBLIC INSURANCE COMPANY	42011
<input type="checkbox"/>	AMPS	21825
<input type="checkbox"/>	AMPS - CX	25667
<input type="checkbox"/>	AMPS America	66775
<input type="checkbox"/>	ARISE HEALTH PLAN	ARISE

Showing 1 to 10 of 41 entries

- Select Clearinghouse

Payer Selection

[...or select individual payers](#)

Payer Name	Payer ID	Clearinghouse Name	Actions
ACTIVA BENEFIT SERVICES LLC	38254	Ability	<input type="button" value="Apply All"/> x
Administrative Concepts, Inc	22384	SDS Enrollment Portal	<input type="button" value="Apply All"/> x
American Family Insurance	56071	SDS Enrollment Portal	<input type="button" value="Apply All"/> x
AMERICAN REPUBLIC INSURANCE COMPANY	42011	SDS Enrollment Portal	<input type="button" value="Apply All"/> x
AMPS	21825	SDS Enrollment Portal	<input type="button" value="Apply All"/> x

- Select "Apply All" to the right of the Clearinghouse Name and you will see the following result

Payer Selection
[...or select individual payers](#)

Payer Name	Payer ID	Clearinghouse Name	Actions
ACTIVA BENEFIT SERVICES LLC	38254	Ability	Apply All ×
Administrative Concepts, Inc	22384	Ability	Apply All ×
American Family Insurance	56071	Ability	Apply All ×
AMERICAN REPUBLIC INSURANCE COMPANY	42011	Ability	Apply All ×
AMPS	21825	Ability	Apply All ×

- The form will automatically have New Enrollment selected. If you click Save Progress and then come back to it, it will say Change Enrollment.
 - This does not affect your enrollment and only indicates that this is no longer the first time you are accessing this form.
- Type in your name for the signature.
- For the effective date, the soonest date available will be three days after the submission date. Any payments you receive after that submission date will have a corresponding ERA sent to your account.

Submission Information
 Reason for SUBMISSION ☺

New Enrollment
 Change Enrollment
 Cancel Enrollment

Authorized Signature

* Signature ☺ _____ Submission Date
 2019-08-27

* Requested ERA Effective Date ☺ _____

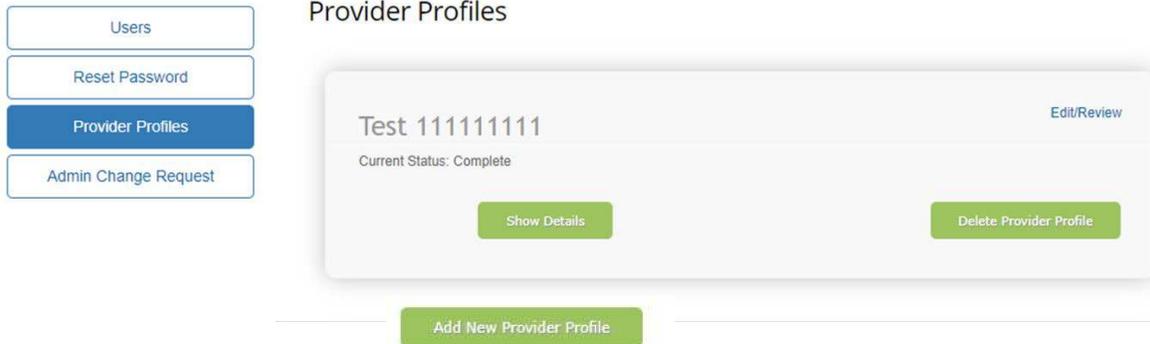
SAVE PROGRESS

SUBMIT

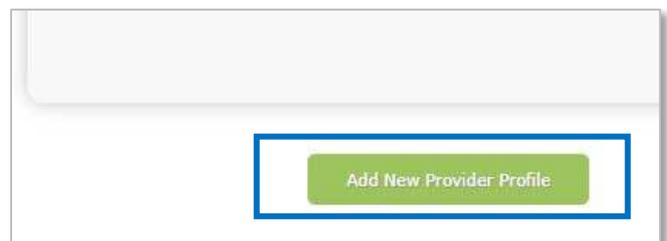
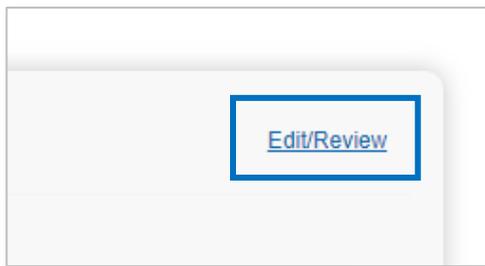
- After you click Submit it will redirect you to a page that looks like this. If you see this page, you have successfully submitted your ERA enrollment.

Account Management

This page is for maintaining account wide preferences such as viewing or re-issuing your API key, or managing payment methods.



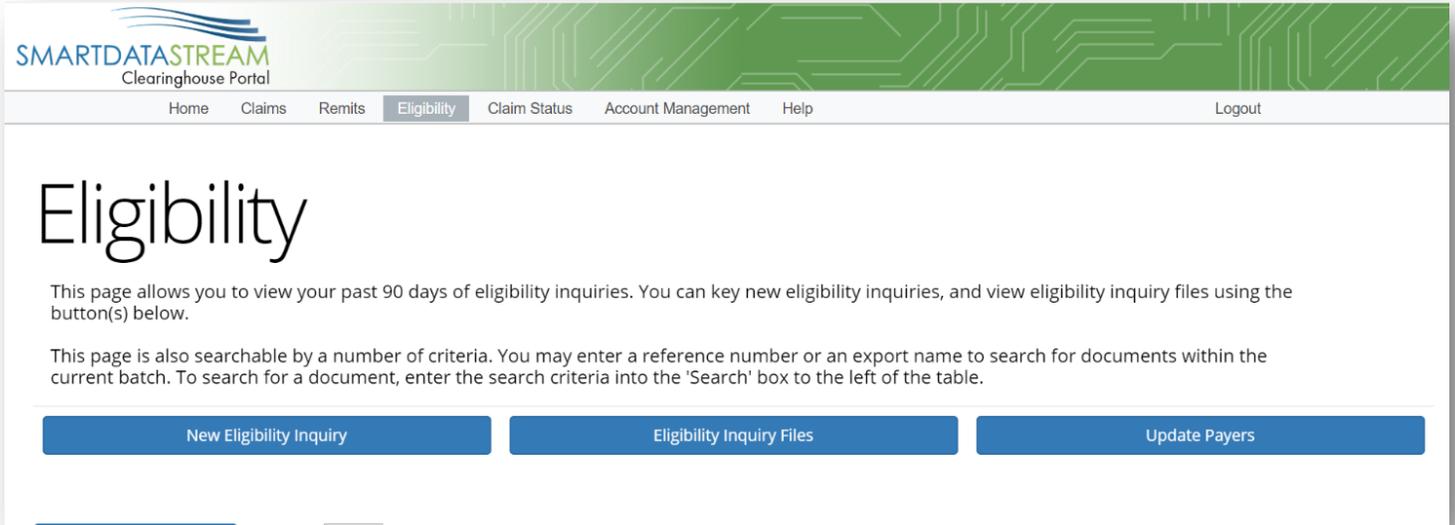
The screenshot shows the 'Provider Profiles' section of the account management interface. On the left, there is a vertical menu with four buttons: 'Users', 'Reset Password', 'Provider Profiles' (which is highlighted in blue), and 'Admin Change Request'. The main content area is titled 'Provider Profiles' and displays a profile for 'Test 111111111'. The profile card includes the text 'Current Status: Complete' and an 'Edit/Review' link in the top right corner. Below the profile name are two green buttons: 'Show Details' and 'Delete Provider Profile'. At the bottom center of the main content area is a green button labeled 'Add New Provider Profile'.



- To change contact information, add or remove payers, change retrieval method, or cancel your enrollment you can click on Edit/Review
- To enroll additional tax ID's or NPI's click Add New Provider Profile

ELIGIBILITY INQUIRY

- Select the Eligibility Tab on the top bar of the page



- Select New Eligibility Inquiry

New Eligibility Inquiry

Mode: Real Time

Destination: American Republic/American Family/Medico/Continental General/Central Reserve Life 270/271 ▼

Subscriber Information

Patient Name * (Last Name, First Name, Middle Initial)			Member Date of Birth *		Member ID *	Insured?
Last	First	Middle	YYYYMMDD	Sex * Male ▼		Yes ▼
Address (No. Street)			City	State	Zip	
Address Line 1			City	State	Zip Code	
Address Line 2						
Inquiry/Service Type: Health Benefit Plan Coverage ▼						
+ Add Inquiry				+ Add Member		
Save Progress		Save Inquiry		Submit Real-Time Request		

- Fill out the starred boxes on the form and click Submit Request

- Results will vary, but will standardly appear in this format:

Eligibility Inquiry Results

Subscriber Name: ██████████
 Member ID: ██████████
 Birthdate: ██████████
 Sex: █
 Address: ████████████████████
 Eligibility Date ██████████

Benefit Information

Search:

	Eligibility Information Code	Plan Description	Coverage Level Code	Service Type Code	Insurance Type Code	Network Indicator	Amount	Percentage	Benefit Dates	Time Period
+	Active Coverage	AR - PLAN F MEDICARE SUPPLEMENT		Health Benefit Plan Coverage						

Eligibility Inquiry Results

Subscriber Name: ██████████
 Member ID: ██████████
 Birthdate: ██████████
 Sex: █
 Address: ████████████████████
 Eligibility Date ██████████

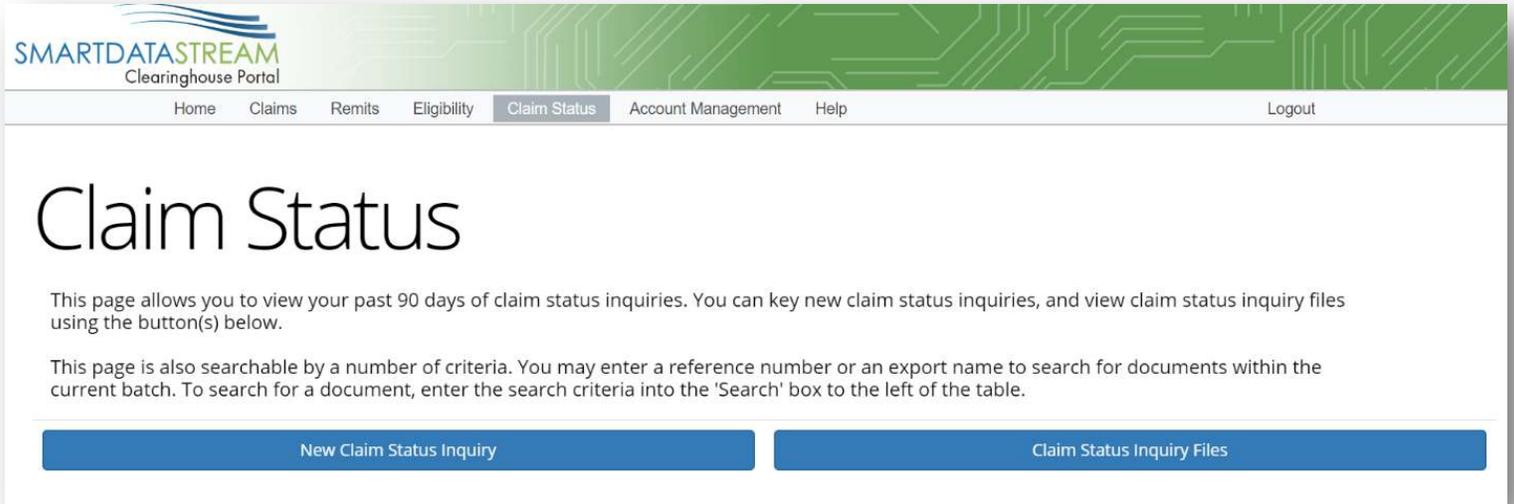
Benefit Information

Search:

	Eligibility Information Code	Plan Description	Coverage Level Code	Service Type Code	Insurance Type Code	Network Indicator	Amount	Percentage	Benefit Dates	Time Period
+	Active Coverage	MEDICARE SUPP PLAN F		Health Benefit Plan Coverage						
+	Active Coverage	MEDICARE SUPP PLAN F		Medical Care Chiropractic Dental Care Hospital Emergency Services Professional (Physician) Visit - Office Vision (Optometry) Mental Health Urgent Care		Not Applicable			Benefit Begin Date : 20160101	
+	Active Coverage	MEDICARE SUPP PLAN F		Chiropractic Pharmacy Medical Care Dental Care Hospital Vision (Optometry) Mental Health Emergency Services Urgent Care Professional (Physician) Visit - Office						
+	Non-Covered	MEDICARE SUPP PLAN F		Pharmacy		Not Applicable			Benefit Begin Date : 20160101	
+	Co-Insurance	MEDICARE SUPP PLAN F		Health Benefit Plan Coverage		Not Applicable		0.00%	Benefit Begin Date : 20160101	Calendar Year
+	Co-Payment	MEDICARE SUPP PLAN F		Health Benefit Plan Coverage		Not Applicable	\$0.00		Benefit Begin Date : 20160101	Calendar Year
+	Deductible	MEDICARE SUPP PLAN F		Health Benefit Plan Coverage		Not Applicable	\$0.00		Benefit Begin Date : 20160101	Calendar Year

CLAIM STATUS

- Select the Claim Status tab on the top bar of the page



- Fill out the starred boxes on the form and click Submit Request

New Claim Status Inquiry

Mode: Real Time

Destination: American Republic/American Family/Medico/Continental General/Central Reserve Life 276/277 ▼

Provider ID *			
Subscriber Name * (Last Name, First Name, Middle Initial)		Subscriber Date of Birth *	Subscriber ID *
Last	First	Middle	YYYYMMDD [calendar icon] Sex: Male ▼
Patient Name (Last Name, First Name, Middle Initial)		Patient Date of Birth	Claim Date of Service
Last	First	Middle	YYYYMMDD [calendar icon] Sex: Male ▼
Procedure Code	Service Date From	Service Date To	Service Charge
	YYYYMMDD [calendar icon]	YYYYMMDD [calendar icon]	

- Results will vary, but will standardly appear in this format:

Claim Status Inquiry Results	
Source Name:	SMART DATA SOLUTIONS
Member ID:	000007600314
Subscriber Name:	GLEASON, JOYCE
Status Information	
Control Number	102617718885
Dates of Service	10/13/2017 - 10/13/2017
Claim Charges	\$ 34.00
Claim Paid Amount	\$ 0.00
Adjudication Date	10/26/2017
The transaction processing has been completed	Cannot provide further status electronically

SUBMITTING A CLAIM

- There are two options to submit a claim through the Smart Data Stream Clearinghouse Portal. You can either upload a claim file or you can do Direct Data Entry and key in a new claim.



Claims

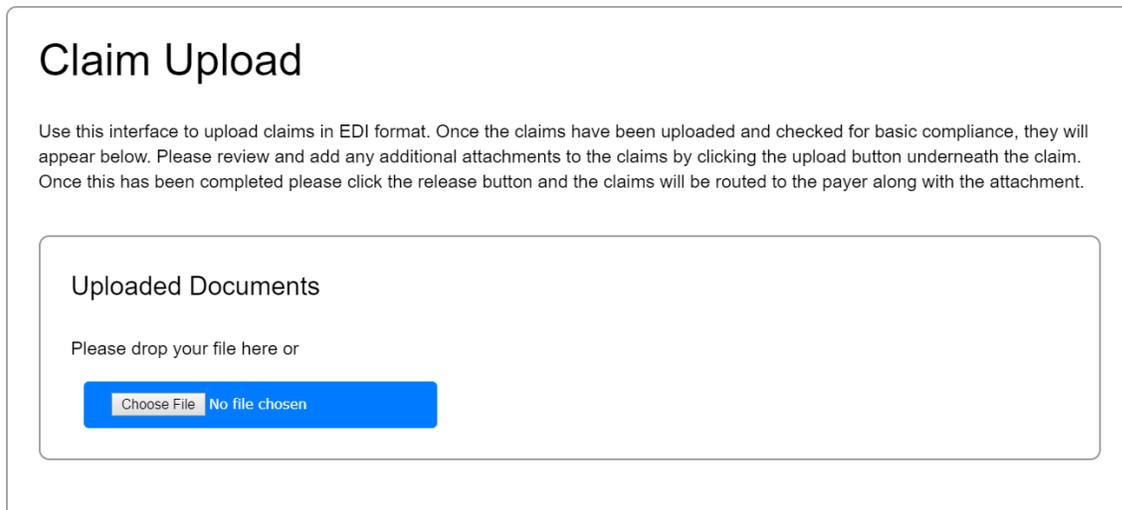
This page allows you to manage your past 90 days of claims. You can edit rejected claims, upload a new claim file, key a new claim, view unsubmitted claims, and view claim files using the button(s) below.

This page is also searchable by a number of criteria. You may enter a reference number or an export name to search for documents within the current batch. To search for a document, enter the search criteria into the 'Search' box to the left of the table.



UPLOAD CLAIMS

- If you selected “Upload Claims”, this screen will appear:



- This feature allows you to upload claims in batches to portal. As long as it's a valid 837 file and has a payer ID in the REF02 segment, SDS will successfully route your claims on to the payer.

NEW CLAIM

- If you selected “**New Claim**”, this screen will appear. From here you can either choose a Professional/CMS1500 claim form, an Institutional/UB04 claim form, or a Dental claim form.

New Document

This data entry page will allow you to key an empty form for processing. To being entering information, please select a destination and a form to key. Once a form is selected you will be automatically redirected to the appropriate page to enter any data. Note that no data is saved until the submit button at the bottom of the page is selected. Once the entry has been completed, there may be a short delay before the entry appears on the history page while the system is processing it.

Please select the appropriate route and form type to begin.

Destination	Document Type
<input type="text" value="Amerigroup"/>	<input type="text" value="Select a Type"/>
	<ul style="list-style-type: none">Select a TypeProfessionalInstitutionalDental

- Once the claim type has been selected, it will bring up a template for the claim information to be typed into. The various document types are shown below:

PROFESSIONAL

More 1. Type OTHER <input type="text"/>		1a. INSURED'S I.D. NUMBER <input type="text"/>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Last <input type="text"/> First <input type="text"/> Middle <input type="text"/>		3. PATIENT'S BIRTH DATE YYYY/MM/DD Sex <input type="text"/>	
5. PATIENT'S ADDRESS (No. Street) <input type="text"/> CITY <input type="text"/> STATE <input type="text"/> ZIP CODE <input type="text"/> TELEPHONE <input type="text"/>		6. PATIENT RELATIONSHIP TO INSURED Self <input type="text"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) <input type="text"/>		8. RESERVED FOR NUCC USE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER <input type="text"/> [More...]		10. IS PATIENT'S CONDITION RELATED TO: Employment? <input type="text"/> No <input type="text"/> Auto Accident? <input type="text"/> No <input type="text"/> Other Accident? <input type="text"/> No <input type="text"/>	
b. RESERVED FOR NUCC USE		11. INSURED'S POLICY GROUP OR FECA NUMBER <input type="text"/>	
c. RESERVED FOR NUCC USE		a. INSURED'S BIRTH DATE YYYY/MM/DD Sex <input type="text"/>	
d. INSURANCE PLAN NAME OR PROGRAM NAME <input type="text"/>		b. OTHER CLAIM ID (Designated by NUCC) <input type="text"/>	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE Signed <input type="text"/>		c. INSURANCE PLAN NAME OR PROGRAM NAME <input type="text"/>	
14. DATE OF CURRENT ILLNESS, INJURY, PREGNANCY (LMP) YYYY/MM/DD QUAL <input type="text"/>		10d. CLAIM CODES (Designated by NUCC) <input type="text"/>	
15. OTHER DATE QUAL <input type="text"/> YYYY/MM/DD		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? No <input type="text"/>	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Last <input type="text"/> First <input type="text"/>		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE Signed <input type="text"/>	
19. RESERVED FOR LOCAL USE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION YYYY/MM/DD TO YYYY/MM/DD	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY A. <input type="text"/> B. <input type="text"/> C. <input type="text"/> D. <input type="text"/> E. <input type="text"/> F. <input type="text"/> G. <input type="text"/> H. <input type="text"/> I. <input type="text"/> J. <input type="text"/> K. <input type="text"/> L. <input type="text"/>		17a. <input type="text"/> 17b. NPI <input type="text"/>	
24. A. DATES OF SERVICE B. POS C. EMG D. PROC MODIFIER E. DIAG F. CHARGE G. DU H. EPSDT I. QUAL J. PROVIDER ID		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES YYYY/MM/DD TO YYYY/MM/DD	
Add Line		20. OUTSIDE LAB? \$ CHARGES No <input type="text"/> 0.00	
25. FEDERAL TAX I.D. NUMBER <input type="text"/>		22. RESUBMISSION CODE ORIGINAL REF. NO. <input type="text"/>	
26. PATIENT'S ACCOUNT NO. <input type="text"/>		23. PRIOR AUTHORIZATION NUMBER <input type="text"/>	
27. ACCEPT ASSIGNMENT? No <input type="text"/>		28. TOTAL CHARGE \$ 0.00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER Last <input type="text"/> First <input type="text"/> Middle <input type="text"/> Credential <input type="text"/>		29. AMOUNT PAID \$ 0.00	
32. SERVICE FACILITY LOCATION INFORMATION Name <input type="text"/> Address <input type="text"/> City <input type="text"/> STATE <input type="text"/> Zip <input type="text"/> Phone <input type="text"/>		30. RSVD for NUCC Use	
a. NPI <input type="text"/>		b. <input type="text"/>	
Save Progress		Save Billing Information	
Submit Document		Submit Document	

INSTITUTIONAL

Name		Name		3a		4 BILL TYPE																															
Addr		Addr		3b																																	
City		City		5 FED TAX NO.		6 STATEMENT COVERS																															
Phone - Fax						7																															
8 Patient Name				9 Patient Address																																	
10 BIRTHDATE		11 SEX		ADMISSION				CONDITION CODES				29 ACCT STATE		30																							
12 DATE		13 PRK		14 TYP		15 SRC		16 DHR		17 STAT		18		19		20		21		22		23		24		25		26		27		28					
31 OCCURRENCE		32 OCCURRENCE		33 OCCURRENCE		34 OCCURRENCE		35 OCCURRENCE		36 OCCURRENCE		37		38		39		40		41		42		43		44		45		46		47		48		49	
CODE		CODE		CODE		CODE		CODE		CODE		CODE		CODE		CODE		CODE		CODE		CODE		CODE		CODE		CODE		CODE		CODE		CODE			
DATE		DATE		DATE		DATE		DATE		DATE		DATE		DATE		DATE		DATE		DATE		DATE		DATE		DATE		DATE		DATE		DATE		DATE			
FROM		THROUGH		FROM		THROUGH		FROM		THROUGH		FROM		THROUGH		FROM		THROUGH		FROM		THROUGH		FROM		THROUGH		FROM		THROUGH		FROM		THROUGH			
NAME		NAME		NAME		NAME		NAME		NAME		NAME		NAME		NAME		NAME		NAME		NAME		NAME		NAME		NAME		NAME		NAME		NAME			
ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS		ADDRESS			
CITY		CITY		CITY		CITY		CITY		CITY		CITY		CITY		CITY		CITY		CITY		CITY		CITY		CITY		CITY		CITY		CITY		CITY			
ZIP		ZIP		ZIP		ZIP		ZIP		ZIP		ZIP		ZIP		ZIP		ZIP		ZIP		ZIP		ZIP		ZIP		ZIP		ZIP		ZIP		ZIP			
42 REV CD		43 DESCRIPTION		44 HCPCS/STATE/PPS CODE		45 SERV DATE		46 SERV UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49																							
Add Line		CREATION DATE		TOTALS >		0.00		0.00																													
50 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO		53 ASS BEN		54 PRIOR PAYMENTS		55 EST AMT DUE		56 NPI		57		58		59		60		61		62		63		64		65		66					
Amerigroup		B1237		Y		Y		0.00		0.00		OTH		PRV ID																							
58 INSURED'S NAME		59 PHEL		60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO																													
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME																																	
66 DX		67		A		B		C		D		E		F		G		H		I		J		K		L		M		N		O		P		Q	
69 ADMIT UX		70 PAT RSN UX		71 PPS CODE		72 ECI		73		74		75		76		77		78		79		80		81		82		83		84		85		86			
74 PROC		DATE		75 PROC		DATE		76 PROC		DATE		77 PROC		DATE		78 PROC		DATE		79 PROC		DATE		80 PROC		DATE		81 PROC		DATE		82 PROC		DATE			
83 AT TEND		NPI		QUAL		LAST		FIRST		84 DIR		NPI		QUAL		LAST		FIRST		85 DIR		NPI		QUAL		LAST		FIRST		86 DIR		NPI		QUAL			
87 DIR		NPI		QUAL		LAST		FIRST		88 DIR		NPI		QUAL		LAST		FIRST		89 DIR		NPI		QUAL		LAST		FIRST		90 DIR		NPI		QUAL			
91 DIR		NPI		QUAL		LAST		FIRST		92 DIR		NPI		QUAL		LAST		FIRST		93 DIR		NPI		QUAL		LAST		FIRST		94 DIR		NPI		QUAL			
95 DIR		NPI		QUAL		LAST		FIRST		96 DIR		NPI		QUAL		LAST		FIRST		97 DIR		NPI		QUAL		LAST		FIRST		98 DIR		NPI		QUAL			
99 DIR		NPI		QUAL		LAST		FIRST		100 DIR		NPI		QUAL		LAST		FIRST		101 DIR		NPI		QUAL		LAST		FIRST		102 DIR		NPI		QUAL			
Save Document Progress																																					

DENTAL

Header Information 1. Type of Transaction Statement of Actual Services <input type="button" value="v"/> 2. Predetermination/Preauthorization Number <input type="text"/>		Policyholder/Subscriber Information Copy from Patient 12. Policyholder/Subscriber Name, Address, State, Zip Name: <input type="text"/> Address: <input type="text"/> Address Line 2: <input type="text"/> City: <input type="text"/> <input type="button" value="v"/> Zip: <input type="text"/> 13. Date of Birth <input type="text"/> <input type="button" value="c"/> 14. Gender <input type="button" value="v"/> 15. Policyholder/Subscriber ID (SSN or ID#) <input type="text"/>																																																																																																													
Insurance Company/Dental Benefit Plan Information 3. Company/Plan Name: American Republic Insurance Address: <input type="text"/> Address Line 2: <input type="text"/> City: <input type="text"/> <input type="button" value="v"/> Zip: <input type="text"/>		16. Plan/Group Number <input type="text"/> 17. Employer Name <input type="text"/>																																																																																																													
Other Coverage 4. Other Dental or Medical Coverage? <input type="button" value="v"/> No 5. Name of Policyholder/Subscriber in #4 <input type="text"/> 6. Date of Birth <input type="text"/> <input type="button" value="c"/> 7. Gender <input type="button" value="v"/> 8. Policyholder/Subscriber ID (SSN or ID#) <input type="text"/> 9. Plan/Group Number <input type="text"/> 10. Patient's Relationship <input type="button" value="v"/> 11. Other Insurance Company/Dental Benefit Plan Name: <input type="text"/> Address: <input type="text"/> City: <input type="text"/> <input type="button" value="v"/> Zip: <input type="text"/>		Patient Information Copy from Subscriber 18. Relationship to Policyholder/Subscriber <input type="button" value="v"/> 19. Student Status <input type="button" value="v"/> 20. Name, Address, City, State, Zip Name: <input type="text"/> Address: <input type="text"/> Address Line 2: <input type="text"/> City: <input type="text"/> <input type="button" value="v"/> Zip: <input type="text"/> 21. Date of Birth <input type="text"/> <input type="button" value="c"/> 22. Gender <input type="button" value="v"/> 23. Patient ID/Account # <input type="text"/>																																																																																																													
Record of Services Provided																																																																																																															
24. Proc Date	25. Area	26. System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee																																																																																																								
<input type="button" value="Add Line"/>																																																																																																															
Missing Teeth Information 34. (Place an 'X' on each missing tooth)		<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td colspan="10" style="text-align: center;">Permanent</td> <td colspan="10" style="text-align: center;">Primary</td> <td rowspan="3" style="width: 10%;"></td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> <td rowspan="2" style="width: 10%;"></td> </tr> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td> <td>A</td><td>B</td><td>C</td><td>D</td><td>E</td><td>F</td><td>G</td><td>H</td><td>I</td><td>J</td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> <td style="text-align: center;">32. Other Fees</td> </tr> <tr> <td>32</td><td>31</td><td>30</td><td>29</td><td>28</td><td>27</td><td>26</td><td>25</td><td>24</td><td>23</td> <td>T</td><td>S</td><td>R</td><td>D</td><td>P</td><td>O</td><td>N</td><td>M</td><td>L</td><td>K</td> <td style="text-align: center;">33. Total Fee</td> </tr> </table>				Permanent										Primary											<input type="checkbox"/>		1	2	3	4	5	6	7	8	9	10	A	B	C	D	E	F	G	H	I	J	<input type="checkbox"/>	32. Other Fees	32	31	30	29	28	27	26	25	24	23	T	S	R	D	P	O	N	M	L	K	33. Total Fee	35. Remarks <input type="text"/>																																							
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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 document. X <input type="text"/> <input type="button" value="c"/> Patient/Guardian signature Date		Auxiliary Claim/Treatment Information 38. Place of Treatment <input type="button" value="v"/> 39. Number of Enclosures <input type="text"/> 40. Is Treatment for Orthodontics? (No <input type="button" value="v"/> 41. Date Appliance Placed <input type="text"/> <input type="button" value="c"/> 42. Months of Treatment Remaining <input type="text"/> 43. Replacement Prosthesis? (No <input type="button" value="v"/> 44. Date Prior Placement <input type="text"/> <input type="button" value="c"/> 45. Treatment Resulting from <input type="button" value="v"/> 46. Date of Accident <input type="text"/> <input type="button" value="c"/> 47. Auto Accident State <input type="button" value="v"/>																																																																																																													
37. I hereby authorize direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. X <input type="text"/> <input type="button" value="c"/> Subscriber signature Date		Billing Dentist or Dental Entity Copy from Treating 48. Name: <input type="text"/> Address: <input type="text"/> Address Line 2: <input type="text"/> City: <input type="text"/> <input type="button" value="v"/> Zip: <input type="text"/> 49. NPI <input type="text"/> 50. License Number <input type="text"/> 51. SSN or TIN <input type="text"/> 52. Phone Number <input type="text"/> 52A. Additional Provider ID <input type="text"/>																																																																																																													
Treating Dentist and Treatment Location Information Copy from Billing 53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed. X <input type="text"/> <input type="button" value="c"/> Signed (Treating Dentist) Date		54. NPI <input type="text"/> 55. License Number <input type="text"/> 56. Address: <input type="text"/> Address Line 2: <input type="text"/> City: <input type="text"/> <input type="button" value="v"/> Zip: <input type="text"/> 57. Phone Number <input type="text"/> 58. Additional Provider ID <input type="text"/>																																																																																																													