Accident Form for Dental Injury

Patient Information

Patient's name	**Member ID number**
Patient date of birth (mm/dd/yyyy)	**Date of accident** (mm/dd/yyyy)

Dear Doctor:

We are requesting information regarding the dental services you provided to the above-named patient. The patient's medical policy with Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas, Health Advantage, or Octave Blue Cross and Blue Shield covers dental treatment only in cases of accidental injury resulting in damage to teeth—and generally only for sound teeth. A sound tooth is defined as one that is intact, free of decay, periodontal disease, or other conditions, and not in need of treatment for any reason other than accidental injury.

To determine a consideration of payment, we require diagnostic x-rays and this completed form. Please review your records and respond to the questions below. Thank you for your assistance.

Accident Details

Were you the first doctor to examine the patient?	**If you answered "No," or if another provider was involved in the patient's treatment, please list the following:**
☐ Yes ☐ No	Hospital emergency department:
	Other doctor(s):

Please provide a brief description of the accident:

List findings from the initial examination. Include the tooth number and describe any observed damage.

Tooth #	Observed damage	**Pre-existing conditions** (e.g., previous restorations)

Provide details of all treatment related to this accident:

Diagnosis code: _____

Date	Tooth #	Service description	Dental code	Fee

Indicate any additional treatment planned as a result of this accident:

Provider Information and Signature

Doctor's signature	**Date signed** (mm/dd/yyyy)		
NPI	**Phone** (xxx-xxx-xxxx)		
Street address	**City**	**State**	**ZIP**