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Date of Service				Procedure Code				Dental Code				Dental Surfaces				Provider Fee				Laboratory Charges				Total Charges				Allocable Amount				Code			

This is an accurate statement of services rendered and the total fee payable.

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Provider Signature _____ Date _____

SSQ C O S F O C A S B S S O

Please carefully fill in all pertinent areas and sign the certificate; or refer to SSQ Identification Card; or correct patient information. Incorrect claims for services will be returned or rejected and will result in a delay in reimbursement.

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All claims must be submitted within 1 month of the date of service.

Patient Name Please Print _____ SSQ Certificate Number _____ Patient Date of Birth _____

Last Name _____ First Name _____

PA - PA FO A O

Patient Name Please Print _____ Patient Date of Birth _____

Last Name _____ First Name _____