[OFFICE LETTERHEAD]

Date _____

Attention: Dental Claims Consultant

Patient Name: _____
DOB: _____
Member ID# _____

D4273-Autogenous Connective Tissue Graft Procedure (first tooth)
D4283- Each additional tooth, Autogenous Connective Tissue Graft Procedure

This procedure has been performed for teeth #'s_____ for the following reasons of defect:

1. Amount of gingival recession _____mm
2. Gingival inflammation: Mild /Moderate/Severe
3. Amount of Keratinized gingiva _____mm
4. Attached gingiva remaining_____mm
5. Unattached gingiva _____mm
6. Root sensitivity: Mild/Moderate/Severe
7. Root/ Cervical Caries Present : YES/NO
8. Periodontal charting dated _____ has been attached to this claim
9. Full mouth x-rays, PA's are attached
10. Procedure is not performed for cosmetic reasons.