



# DENTAL CLAIM FORM

## GENERAL INFORMATION

Use this claim form to submit a claim for services which are covered under your dental program. To avoid delay in having your claim processed, please complete a separate claim form for each patient, and be sure that all information is complete and correct. Items 1 through 12 of this form must be completed by the subscriber or spouse, and items 13 through 21 are to be completed by the dentist.

When the claim form has been completed and signed, please mail it to your local Blue Cross and Blue Shield Plan.

### INSTRUCTIONS FOR COMPLETING PATIENT AND SUBSCRIBER INFORMATION

**Items 1-11:** Complete all items as indicated on the front of the form.

**Item 9:** Please check yes or no in item 9. If yes, please provide information requested regarding your other dental insurance coverage. If payment has been received from another insurance company, please attach a copy of their Explanation of Benefits.

**Item 12:** **ASSIGNMENT OF BENEFITS** – Benefits for services provided by participating dentist are payable directly to the dentist, whether or not benefits are assigned. Benefits for services provided by non-participating dentists located within our service area are made payable directly to the subscriber, regardless of any assignment of benefits. However, if the non-participating dentist is located outside our service area and you would like benefits due you for this claim sent directly to the dentist, complete item 12 on the reverse of this form. Also be sure the dentist's Tax ID Number or Social Security Number is included in item 21 with the dentist's name and address.

### INSTRUCTIONS FOR COMPLETING DENTIST INFORMATION

**Item 13:** **MISSING TEETH** – Each claim for services involving missing or extracted teeth must include the information requested in item 13. To assist us in updating our records, with the submission of an initial oral exam, please include a complete charting of the patient's dentition.

**Item 14:** **ORTHODONTIA** – Claims for orthodontic services must include the information requested in item 14. It is not necessary for the orthodontic treatment to be completed before submitting the claim.

**Item 15:** **CROWNS, BRIDGES, AND DENTURES** – Please complete this information on any claim for a crown, bridge or denture. See item 20 below for x-ray requirements.

**Item 16:** **CONSULTATIONS** – Claims for consultations must include a report from the consulting specialist indicating the name of the referring dentist or physician, the reason for the consultation, the treatment being considered and a description of the patient's oral condition.

**Item 17:** **ADA PROCEDURE CODES** – American Dental Association codes

**TOOTH NO. OR LETTER** – Refer to tooth chart on front of this claim form.

**SURFACES** – Use the following codes to identify tooth surfaces:

B = Buccal or facial    D = Distal    O = Occlusal

M = Mesial    I = Incisal    L = Lingual

**PLACE** – Please check the appropriate column on the claim form to indicate the place of service:

Off = Office    IN = Inpatient Hospital    OP = Outpatient Hospital

**CHARGE** – Indicate the individual charge for each service listed.

**Item 18:** **DENTIST'S CERTIFICATION AREA** – Please check the appropriate box to indicate whether the services listed have been completed. The dentist's signature and telephone number must also be completed in item 18.

**ESTIMATE OF ELIGIBLE BENEFITS** – If no dates of service are indicated on the claim, we will provide an estimate of the benefits available for the services listed. The estimates are based on the information we have at the time the claim is reviewed. Estimates will be subject to eligibility, deductibles, and Plan maximums. Therefore, they may be affected by other payments made between the time the estimate is given and the time that the services are rendered. Actual payments will be made in the order that claims are received.

If you are requesting a Estimate of Eligible Benefits, mark the Estimate of Eligible Benefits box in item 18. In addition the dentist's name, address, and Tax ID Number or Social Security Number must be clearly written in item 21 of this claim form.

**Item 20:** **X-RAYS** – Postoperative x-rays are required for the review of claims for root canals. These x-rays are also needed to review claims for posts and cores following the root canals. Pre-operative x-rays are required for review of claims for crowns, crown build-ups, bridges, partial dentures and apicoectomies. For periodontal procedures, we need the most recent pre-operative x-rays and complete periodontal charting of the teeth involved in the treatment. We may also occasionally request x-rays for certain other procedures. All x-rays will be returned to the dentist's after the claim has been reviewed. To expedite the processing of your claim and to assist us in the return of the x-rays, please include the patient's name and identification number as well as the dentist's name and address on the x-ray or x-ray envelope.

**Item 21:** Each claim must include the dentist's name, address and Tax ID Number or Social Security Number. Please also check the appropriate box in item 21 to indicate the type of identification number used.