DENTAL CLAIM FORM

BlueCross BlueShield
Federal Employee Program®

PLEASE TYPE OR PRINT

1. Identification Number

2. Group Number or Enrollment Code

3. Patient's Name *(First, Middle Initial, Last)*

4. Patient's Date of Birth (MM/DD/YYYY)

5. Patient's Sex ◯ Female ◯ Male

6. Patient's Relationship to Subscriber: ◯ EE/Self ◯ SP/Spouse ◯ CH/Child ◯ Other Explain:

7. Subscriber's Name *(First, Middle Initial, Last)*

8. Daytime Telephone Number *(Include Area Code)*

9. Subscriber's Address
Street or Box Number
City **State** **Zip Code**
CHECK IF NEW ADDRESS ☐

10. Email Address

11. Is the patient covered under other dental insurance? ◯ Yes ◯ No
If yes, name of other insurance
Name of Policy Holder
Other Policy ID Number

12. If patient's condition is due to an accident, give the date of accident: (MM/DD/YYYY)
Was another party at fault? ◯ Yes ◯ No

12a. If patient's condition is due to an accident, was it due to:
Work related accident? ◯ Yes ◯ No
An auto accident? ◯ Yes ◯ No
Other Accidental Injury? ◯ Yes ◯ No

13. THIS CLAIM FORM MUST BE SIGNED. IF NOT, IT WILL BE RETURNED. I certify that the above information is correct and apply for benefits under my dental coverage. I authorize any dentist or physician in possession of information concerning the patient to furnish such information upon request.

Signature of Subscriber or Spouse *Date*

14. ASSIGNMENT OF BENEFITS: (Please see the reverse side of this form for further information.) ◯ Yes ◯ No
If the "yes" block above is marked, I authorize the Blue Cross and Blue Shield Plan to pay benefits directly to the provider of the services listed below. The Plan, at its discretion, may accept or deny an assignment of benefits.

Signature of Subscriber or Spouse *Date*

To be completed by Dentist (See instructions on reverse.)

15. MISSING TEETH: Identify missing teeth by utilizing the tooth number tables on the reverse side of this form. Indicate by tooth number, the date each tooth was lost or extracted, if known:
Tooth Date Tooth Date Tooth Date Tooth Date Tooth Date
Tooth Date Tooth Date Tooth Date Tooth Date Tooth Date

16. ORTHODONTIA: Is orthodontic treatment included in the services listed below? ◯ Yes ◯ No If yes, is this initial treatment? ◯ Yes ◯ No
Date appliance was placed: Expected completion date of orthodontic treatment: Total charge for active treatment:

17. CROWNS, BRIDGES AND DENTURES:
Do services include the replacement of a prosthesis (crown, bridge, denture)? ◯ Yes ◯ No If yes, what was the original prosthesis?
Indicate date of original placement or restoration and original teeth involved: (MM/DD/YYYY) Tooth Number(s)
Reason for replacement: ◯ Original Damaged ◯ Lost or stolen Other: (explain)
See item 22 on the back of this form for X-ray requirements.

18. Do charges include a consultation? ◯ Yes ◯ No If yes, name of referring provider
A report from the consulting specialist is required. See item 18 on the back of this form for additional information required for a consultation.

19. Description of Services (See instructions on reverse.)

Date of Service (MM/DD/YYYY)	A.D.A. Procedure Code	Detailed Description of Services	Tooth # or Letter	Surfaces	# of Times Performed	Place of Service			Charge
						◯ Office	◯ Inpatient	◯ Outpatient	
						◯ Office	◯ Inpatient	◯ Outpatient	
						◯ Office	◯ Inpatient	◯ Outpatient	
						◯ Office	◯ Inpatient	◯ Outpatient	
						◯ Office	◯ Inpatient	◯ Outpatient	
						◯ Office	◯ Inpatient	◯ Outpatient	
						◯ Office	◯ Inpatient	◯ Outpatient	

20. Please check the appropriate box.
◯ **ESTIMATE OF ELIGIBLE BENEFITS:** The treatment listed is necessary in my professional judgement and I request Estimate of Eligible Benefits. Note: Dentist's Tax ID Number or Social Security Number is required.
◯ **WORK COMPLETED - PAYMENT REQUESTED:** I certify that the services have been performed by me or under my personal supervision and are necessary in my professional judgement. Charges shown are my usual charges.
Dentist's Signature Phone #

21. TOTAL CHARGE

22. Are X-rays enclosed? ◯ Yes ◯ No
(See item 22 on the back of this form.)

23. Dentist's Name
Address
License Number
National Provider Identification Number (NPI)
◯ Tax ID Number ◯ Social Security Number

Clear Form

DENTAL CLAIM FORM

GENERAL INFORMATION

Use this claim form to submit a claim for services that 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 14 of this form must be completed by the subscriber or spouse, and items 15 through 23 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 company.

INSTRUCTIONS FOR COMPLETING PATIENT AND SUBSCRIBER INFORMATION

Items 1-14: Complete all items as indicated on the front of the form.

Item 11: Please check yes or no in item 11. 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 14: ASSIGNMENT OF BENEFITS - Benefits for services provided by participating dentists are made 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 14 on the reverse side of this form. Also, be sure the dentist's Tax ID Number or Social Security Number is included in item 23 with the dentist's name and address.

INSTRUCTIONS FOR COMPLETING DENTIST INFORMATION

Tooth Number Tables

Adult Tooth Numbers Upper Arch - commencing in the upper right quadrant and rotating counterclockwise																
Tooth #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Supernumerary Tooth #	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66

Adult Tooth Numbers Lower Arch - commencing in the upper right quadrant and rotating counterclockwise																
Tooth #	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
Supernumerary Tooth #	82	81	80	79	78	77	76	75	74	73	72	71	70	69	68	67

Primary Tooth Numbers Upper Arch - commencing in the upper right quadrant and rotating counterclockwise										
Tooth #	A	B	C	D	E	F	G	H	I	J
Supernumerary Tooth #	AS	BS	CS	DS	ES	FS	GS	HS	IS	JS

Primary Tooth Numbers Lower Arch - commencing in the upper right quadrant and rotating counterclockwise										
Tooth #	T	S	R	Q	P	O	N	M	L	K
Supernumerary Tooth #	TS	SS	RS	QS	PS	OS	NS	MS	LS	KS

Item 15: MISSING TEETH - Each claim for services involving missing or extracted teeth must include the information requested in item 15. 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 16: ORTHODONTIA - Claims for orthodontic services must include the information requested in item 16. It is not necessary for the orthodontic treatment to be completed before submitting the claim.

Item 17: CROWNS, BRIDGES AND DENTURES - Please complete this information on any claim for a crown, bridge or denture. See item 22 below for X-ray requirements.

Item 18: 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 19: ADA PROCEDURE CODES - American Dental Association codes

TOOTH NO. OR LETTER - Refer to the tooth chart above.

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: Office, Inpatient Hospital or Outpatient Hospital

CHARGE - Indicate the individual charge for each service listed.

Item 20: 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.

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 the claims are received.

If you are requesting an Estimate of Eligible Benefits, mark the Estimate of Eligible Benefits box in item 20. In addition, the dentist's name, address,and Tax ID Number or Social Security Number must be clearly written in item 23 of this claim form.

Item 22: X-RAYS - Post-operative 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 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 envelope.

Item 23: Each claim must include the dentist's name, address and Tax ID Number or Social Security Number. Please also check the appropriate box in to indicate the type of identification number used.