## **Dental Claim Form**

HEADER INFORMATION			1													
1. Type of Transaction (Mark all ap			(i) Health Advantage													
Statement of Actual Services	ermination	ıthorizatio	An independent Licenses of the Blue Cross and Blue Shield Association													
EPSDT/Title XIX																
Predetermination/Preauthorization Number									POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)							
									12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code							
INSURANCE COMPANY/DEN	MATION		1													
3. Company/Plan Name, Address, City, State, Zip Code																
									13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscriber ID (SSN						r ID#)	
						MF										
OTHER COVERAGE			16. Plan/Group I	Number	17. Em	ployer Name										
4. Other Dental or Medical Coveraç	Yes (	ete 5-11)														
5. Name of Policyholder/Subscribe	uffix)		PATIENT INFORMATION													
									18. Relationship to Policyholder/Subscriber in #12 Above 19. Student Status							
6. Date of Birth (MM/DD/CCYY)	Gender 8. Policyholder/Subscriber ID (SSN or ID#)						Self Spouse Dependent Child Other FTS P							PTS		
							20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code							$\overline{}$		
9. Plan/Group Number																
Self Spouse Dependent Other																
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code																
								21. Date of Birth	(MM/DD/CCY	Y) 22. G	Gender	23. Patient ID/A	Account # (Assig	ned by [	Dentist)	
RECORD OF SERVICES PRO	OVIDED							•								
24. Procedure Date 25.	Area 26		'. Tooth Numb	er(s)	28.	Tooth	29. Proced	lure							_	
	avity Syst	II IUUIII or Latter(s)			Surface		Code		30. Description						Fee	
1																
2																
3																
4																
5																
6																
7																
8																
9																
10																
MISSING TEETH INFORMATI	ION				Permar	nent				F	Primary		32. Other			
34. (Place an 'X' on each missing to	ooth)	1 2 3	3 4 5	6 7	8	9 10	11 12	13 14 15 16	S A B	C D E	F G	H I J	Fee(s)		i	
04. (Flado all X off dadif filloding to		32 31 3	0 29 28	27 26	25	24 23	22 21	20 19 18 17	T S	R Q P	ON	M L K	33.Total Fee		i	
35. Remarks																
AUTHORIZATIONS				ANCILLARY CLAIM/TREATMENT INFORMATION												
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or									38. Place of Treatment  39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)							
the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health									Provider's Office Hospital ECF Other							
information to carry out payment activities in connection with this claim. Any person who knowingly presents									40. Is Treatment for Orthodontics?  41. Date Appliance Placed (MM/DD/CCYY)							
a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.									No (Skip 41-42) Yes (Complete 41-42)							
XPatient / Guardian signature Date									42. Months of Treatment Remaining 43. Replacement of Prosthesis? 44. Date Prior Placement (MM/DD/CCYY)							
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named										No Yes	(Complete 4	4)				
dentist or dental entity.									esulting from		_	_	_			
X									Cccupational illness/injury Auto accident Other accident							
Subscriber signature Date									46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State							
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting									TREATING DENTIST AND TREATMENT LOCATION INFORMATION							
claim on behalf of the patient or ins	53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.															
48. Name, Address, City, State, Zip Code									,							
								x								
								Signed (Treating Dentist)  Date								
								54. NPI 55. License Number								
								56. Address, City, State, Zip Code 56A. Provider Specialty Code								
49. NPI	50. Licer	nse Number		51. SSN	or TIN										I	
50 B			T	<u></u>				57.5								
52. Phone	_		52A. Additio	nal				57. Phone	)	_	58. A	dditional				

## **HOW TO FILE A CLAIM**

- 1. Complete boxes 1 23.
- 2. Please make sure box 15 contains your member number <u>as it appears on your ID card</u>. **Do not use your social security number in this box**.
- 3. Be sure to sign the authorization to release information in box 36.
- 4. Ask your dentist to complete boxes 24 58, or attach an original itemized billing from the dentist on his/her letterhead or approved ADA claim form that includes all information requested in boxes 24-58.
- 5. Attach all related Explanation of Benefits statements for other coverage if applicable.
- 6. Send completed claim form to:

Dental Claims Administrator PO Box 69436 Harrisburg, PA 17106-9436

NOTE: Subscriber submitted claim forms must be submitted within 180 days of the date of service. Claims which cannot be identified due to incomplete subscriber information will be returned.

## **HOW TO REACH US**

Phone: • Members - (888) 223-4999

• Providers - (888) 224-5213

Write: Dental Customer Service

PO Box 69437

Harrisburg, PA 17106-9437