MEMBER DENTAL CLAIM FORM

Please type or print

1. Identification Number	2. Group Number	3. Patient's name *(First, Middle Initial, Last)*

4. Patient's Date of Birth	5. Patient's Sex	6. Patient's Relationship to Subscriber:
Month / Day / Year	Female ☐	Self ☐ Child ☐
	Male ☐	Spouse ☐ Other ☐ Explain:_____

7. Subscriber's Name *(First, Middle Initial, Last)*	8. Daytime Telephone Number *(include Area Code)*

Subscriber's Address *(Street and Apt. or Box Number)*	City	State	Zip Code

9. Is the patient covered under other dental insurance?

No Yes

If yes, name of insurance: _____

Name of Policy Holder_____

Other Policy ID Number_____

10. Was patient's condition due to:

Work related accident? No ☐ Yes ☐
An auto accident? No ☐ Yes ☐
Other accidental Injury? No ☐ Yes ☐

If yes, give the date of accident ____/____/____
Mo. Day Year

Please attach a statement with details indicating when, where and the manner in which the injury occurred.

Was another party at fault? No ☐ Yes ☐

11. ORTHODONTIA:

Is orthodontic treatment included in the services listed below?

No ☐ Yes ☐

If yes, is this initial treatment? No ☐ Yes ☐

Date appliance was placed: _____

Expected completion date of orthodontic treatment: _____

Total charges for active treatment _____

12. 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 with CareFirst BlueCross BlueShield or CareFirst BlueChoice. I authorize any dentist or physician in possession of information concerning the patient to furnish such information to CareFirst BlueCross BlueShield or CareFirst BlueChoice upon request.

_____
Signature of Subscriber or Spouse *Date*

13. CROWNS, BRIDGES AND DENTURES:

Do services include the replacement of prosthesis (crown, bridge, denture)? No ☐ Yes ☐

If yes, what was the original prosthesis? Mo. Day Year Tooth Number(s)

Indicate date of original placement or restoration and original teeth involved: ____/____/____ _____

Reason for replacement: Original Damaged ☐ Lost or Stolen ☐ Other ☐
(Explain) _____
See item 17 of the instructions for X-ray requirements

14. ASSIGNMENT OF BENEFITS: (See instruction page.) **The Plan may, at its discretion, accept or deny an assignment of benefits.**

No ☐ Yes ☐

If "yes" block above is marked, I authorize CareFirst BlueCross BlueShield or CareFirst BlueChoice to pay benefits directly to the provider of the services listed.

_____ _____
Signature of Subscriber or Spouse Date

15. DESCRIPTION OF SERVICES (See instructions on reverse.)

Date of Service			A.D.A. Procedure Code	Detailed Description of Services	Tooth No. or Letter	Surfaces	# Times Perf.	Charge
M	D	Y						
								.
								.
								.
								.
								.
								.
								.

16. TOTAL CHARGES ..... .

17. ARE X-RAYS ENCLOSED?

No ☐ Yes ☐ (See instructions page.)

18. PLEASE CHECK APPROPRIATE BOX

☐ ESTIMATE OF ELIGIBLE BENEFITS
The treatment listed is necessary in my professional judgement and I request an Estimate of Eligible Benefits.
NOTE: Dentist's Tax ID Number or Social Security Number is required

☐ WORK COMPLETED — PAYMENT REQUESTED
I certify that the above 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 #

19.

Dentist Name

☐ *Tax ID No. or* ☐ *SSN*

Address

City *State* *Zip Code*

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MEMBER DENTAL CLAIM FORM

Instructions

Use this claim form to submit a claim for services, which maybe 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. We will return the form to you for the information if each question is not answered. Items 1 through 10 of this form must be completed.

Item 1-19:
Complete all items as indicated on the front form.

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

Item 11:
ORTHODONTIA - Claims for orthodontic services must include the information requested in item 14. It is not necessary for the othodontic treatment to be completed before submitting the claim.

Item 13:
CROWNS, BRIDGES, AND DENTURES - Please complete this information on any claim for a crown, bridge or denture. See item 17 below for X-ray requirements.

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 buy non-participating dentist located within our service area are made payable directly to the subscriber, regardless of any assignment of benefits (except for Virginia non-participating providers when benefits have been assigned).

Item 15:
DATE OF SERVICE - Month, day and year of services were rendered.
ADA PROCEDURE CODES - Most recent American Dental Association codes.
TOOTH NUMBERS - 1 to 32 for permanent dentition, A to for primary (deciduous) dentition.
SURFACES - Use the following codes to identify tooth surfaces: B = Buccal or facial D = Distal O = Occlusal M = Mesial I = Incisal L = Lingual
CHARGE - Indicate the individual charge for each service listed.

Item 17:
X-ray's are needed to review claims for posts and cores following root canals. Pre-operative X-rays are required for review of claims for crowns and bridges. For periodontal procedures, we need the mot 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 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 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 the claims are received.

If you are requesting an Estimate of Eligible Benefits, mark the Estimate of Eligible benefits box in item 18. In addition, the dentist's address, and Tax ID Number or Social Security Number must be clearly written in item 19 of this claim form.

Item 19:
Each claim must include a bill (on letterhead stationary) with the dentist's name, address and Tax Identification Number or Social Security Number. Please also check the appropriate box in item 19 to indicate the type of identification number used. Please keep copies; bills cannot be returned.

When the claim form has been completed and signed, please mail it to:

Mail Administrator
P.O. Box 14115
Lexington, KY 40512-4115