

Dental Claim Form



**Arkansas
Blue Cross Blue Shield**
An Independent Licensee of the Blue Cross and Blue Shield Association

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
- Statement of Actual Services Request for Predetermination/Preauthorization
- EPSDT/ Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? No (Skip 5-11) Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN or ID#)

M F

9. Plan/Group Number 10. Patient's Relationship to Person Named in #5

Self Spouse Dependent Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscriber ID (SSN or ID#)

M F

16. Plan/Group Number 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above 19. Student Status

Self Spouse Dependent Child Other FTS PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assigned by Dentist)

M F

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)	Permanent																Primary										32. Other Fee(s)	33. Total Fee
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K		

35. Remarks

AUTHORIZATIONS

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 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 information to carry out payment activities in connection with this claim. Any person who knowingly presents 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.

X _____ Date
Patient / Guardian signature

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____ Date
Subscriber signature

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. NPI 50. License Number 51. SSN or TIN

52. Phone Number () - 52A. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 39. Number of Enclosures (00 to 99)

Provider's Office Hospital ECF Other Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? 41. Date Appliance Placed (MM/DD/CCYY)

No (Skip 41-42) Yes (Complete 41-42)

42. Months of Treatment Remaining 43. Replacement of Prosthesis? 44. Date Prior Placement (MM/DD/CCYY)

No Yes (Complete 44)

45. Treatment Resulting from

Occupational illness/injury Auto accident Other accident

46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____ Date
Signed (Treating Dentist)

54. NPI 55. License Number

56. Address, City, State, Zip Code 56A. Provider Specialty Code

57. Phone Number () - 58. Additional Provider ID

HOW TO FILE A CLAIM

1. Complete boxes 1 – 23.
2. Please ensure box 15 contains your member number as it appears on your ID card.
3. Be sure to sign the authorization to release information in block 36.
4. If you wish to have your benefits paid directly to your dentist, sign block 37.
5. 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 blocks 24-58.
6. Attach all related Explanation of Benefits statements for other coverage if applicable.
7. PLEASE KEEP COPIES OF YOUR BILLS PRIOR TO SENDING THE ORIGINALS WITH THIS CLAIM. SERVICES THAT ARE DENIED FOR PAYMENT WILL BE NOTED ON YOUR EXPLANATION OF BENEFITS. NO BILLS ARE RETURNED TO YOU EVEN IF THEY ARE DENIED FOR PAYMENT.
8. Send completed claim form to:

Dental Claims Administrator
P.O. Box 1206
Elk Grove Village, IL 60009-1206

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

HOW TO REACH US

By Phone:

Please call the phone number on the front of your identification card or our general customer service line at 1-877-203-9921.

Write:

Customer Correspondence
P.O. Box 45132
Jacksonville, FL 32232-9902