

# Dental Claim Form Completion Instructions

## Data Element Specific Instructions

Form completion instructions are provided for each data item, which is indicated by a number. Please note that data items are in groups of related information. These instructions explain the reasons for such groupings, and the relationships (if any) between groups.

## IMPORTANT INFORMATION

When it is necessary for you to file the claim, you will need to complete item numbers 1-23 and 36-37. You will need to attach a signed super bill or statement from your dentist that reflects the treatment you received.

### Mail completed form to:

BlueCross BlueShield of Tennessee  
Dental Department  
P. O. Box 180150  
Chattanooga, TN 37401-7150

## Header Information

The “header” provides information about the type of submission being made. This information applies to the entire transaction.

HEADER INFORMATION	
1. Type of Transaction (Check all applicable boxes)	
<input type="checkbox"/> Statement of Actual Services	<input type="checkbox"/> Request for Predetermination / Preauthorization
<input type="checkbox"/> EPSDT/ Title XIX	
2. Predetermination / Preauthorization Number	

### 1. Type of Transaction:

There are three boxes that may apply to this submission. If services have been performed, check the “Statement of Actual Services” box. If there are no dates of service, check the box marked “Request for Predetermination/Preauthorization”. If the claim is through the Early and Periodic Screening, Diagnosis and Treatment Program, check the box marked “EPSDT/Title XIX”.

### 2. Predetermination/Preauthorization Number:

If you are submitting a claim for a procedure that has been pre-authorized by a third party payer, enter the preauthorization or predetermination number provided by the insurance company.

### Primary Payer Information

PRIMARY PAYER INFORMATION
3. Name, Address, City, State, Zip Code

- 3. Name, Address, city, State, Zip Code:** This item is always completed. Enter the information for the insurance company or third-party payer. If the patient is covered by more than one plan, enter the primary insurance company information here.

## Other Coverage

The “other coverage” area of the claim form provides information on the existence of additional dental or medical insurance policies. This is necessary to determine if multiple coverages are in effect, and the possibility of coordination of benefits.

OTHER COVERAGE		
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)		
5. Subscriber Name (Last, First, Middle Initial, Suffix)		
6. Date of Birth (MM/DD/CCYY)	7. Gender <input type="checkbox"/> M <input type="checkbox"/> F	8. Subscriber Identification Number
9. Plan/Group Number	10. Relationship to Primary Subscriber (Check applicable box) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	
11. Other Carrier Name, Address, City, State, Zip Code		

- 4. Other Dental or Medical Coverage?:** If there is no other coverage, check the box marked “No” and skip to Item #12. If there will be a claim made to a second insurance company, check the box marked “Yes” and complete Items 5 - 11.
- 5. Other Insured’s Name (Last, First, Middle, Suffix):** Enter the name of the individual who is insured through another dental or medical plan. If the patient has secondary coverage through a spouse, domestic partner or, if a child, through both parents, the name of the person who has the secondary coverage should be reported here.
- 6. Date of Birth (MM/DD/CCYY):** Enter the date of birth of the person listed in Item #5. The date must be entered with two digits each for the month and day and four digits for the year of birth.
- 7. Gender:** Enter the gender of the person who is listed in Item #5. Check “M” for Male or “F” for Female, as applicable.
- 8. Subscriber Identification Number:** Enter the subscriber identification number of the person who is listed in Item #5. The identifier number is a number assigned by the payer/insurance company to this individual.
- 9. Plan/Group Number:** Enter the group plan or policy number of the person identified in Item #5.
- 10. Patient’s Relationship to Other Insured (Check applicable box):** Enter the patient’s relationship to the other (secondary) insured named in Item #5.
- 11. Other Carrier Name, Address, City, State, Zip Code:** Enter the complete information of the additional payer, benefit plan or entity for the insured named in Item #5.

## Primary Insured Information

This section documents information about the insured person who may or may not be the patient.

PRIMARY SUBSCRIBER INFORMATION		
12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code		
13. Date of Birth (MM/DD/CCYY)	14. Gender <input type="checkbox"/> M <input type="checkbox"/> F	15. Subscriber Identification Number
16. Plan/Group Number	17. Employer Name	

- 12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code:** Enter the complete name, address and zip code of the primary insured/employee.
- 13. Date of Birth (MM/DD/CCYY):** A total of eight digits are required in this field; two for the month, two for the day of the month, and four for the year.
- 14. Gender:** This applies to the primary insured, who may or may not be the patient. Check “M” for male or “F” for female.
- 15. Subscriber Identification Number:** Enter the subscriber identification number of the primary insured that has been assigned to the primary insured by the payer or insurance company.
- 16. Plan/Group Number:** Enter the primary insured’s group plan/policy number.
- 17. Employer Name:** If applicable, enter the name of the insured’s employer.

## Patient Information

The information in this section of the claim form pertains to the patient.

PATIENT INFORMATION		
18. Relationship to Primary Insured (Check applicable box) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other		19. Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code		
21. Date of Birth (MM/DD/CCYY)	22. Gender <input type="checkbox"/> M <input type="checkbox"/> F	23. Patient ID/Account # (Assigned by Dentist)

- 18. Relationship to Primary Insured (Check applicable box):** Enter the relationship of the patient to the person identified in Item #12 who has the primary insurance coverage. The relationship between the insured and the patient may affect the patient’s eligibility or benefits available. **If the patient is also the primary insured, mark the box titled “Self” and skip to Item #23.**

- 19. Student Status:** Check “FTS” if patient is a dependent and a full-time student. Check “PTS” if the patient is a dependent and a part-time student. If neither applies, skip to Item #20.
- 20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code:** Enter the complete name, address and zip code of the patient.
- 21. Date of Birth (MM/DD/CCYY):** A total of eight digits are required in this field; two for the month, two for the day of the month, and four for the year of birth of the patient.
- 22. Gender:** This applies to the patient. Check “M” for male or “F” for female.
- 23. Patient ID/Account# (Assigned by Dentist):** Enter if the dentist’s office has assigned a number to identify the patient. This is not required to process claim.

**Attach a signed super bill/statement from your dentist that reflect the treatment that you received and skip to Item # 36.**

### Authorizations

This section provides consent for treatment as well as permission for the payer to send any patient benefit available for procedures performed directly to the dentist or the dental business entity.

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.	
X _____	_____
Patient/Guardian signature	Date
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 _____	_____
Subscriber signature	Date

- 36. Patient Consent:** The patient is defined as an individual who has established a professional relationship with the dentist for the delivery of dental health care. For matters relating to communication of information and consent, the term includes the patient’s parent, caretaker, guardian, or other individual as appropriate under state law and the circumstances of the case.  
  
By signing (or signature on file notice) in this location of the claim form, the patient or patient’s representative has agreed that he/she has been informed of the treatment plan, the costs of treatment and the release of any information necessary to carry out payment activities related to the claim.
- 37. Insured’s Signature:** The signature and date (or signature on file notice) are required when the insured wishes to have benefits paid directly to the dentist/provider. This is an authorization of payment. It does not create a contractual relationship between the dentist or dental entity and the insurance company.