

Get Reimbursed for Out-of-Pocket Payments



If you paid out of pocket for care from a dental provider who isn't in your network, you may be able to get some of your money back. Fill out the dental claim form included in this document and mail it to us along with a signed statement (sometimes called a "superbill") from your dentist.

You'll need to file your claim within 15 months of the date of care.

Please send your form to:

**BlueCross BlueShield of Tennessee
Claims Service Center
1 Cameron Hill Circle Suite 0002
Chattanooga, TN 37402-0002**

Note: Save a copy of the completed claim form and superbill/statement for your records.



**Stay in network
and save on
your next visit.**

You'll pay less for your care when you go to a provider in your network. Here's how to find one.

Online:

1 [bcbst.com/finddentalcare](https://www.bcbst.com/finddentalcare)

Use the BCBSTNSM app:

2 Tap **Get Care**, then **Dental**.

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes) Request for Predetermination/Preauthorization

Statement of Actual Services EPSDT / Title XIX

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

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

3a. Payer ID

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? Medical? (If both, complete 5-11 for dental only.)

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

6. Date of Birth (MM/DD/CCYY)

7. Gender
 M F U

8. Policyholder/Subscriber ID (Assigned by Plan)

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

11a. Other Payer ID

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan 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
 M F U

15. Policyholder/Subscriber ID (Assigned by Plan)

16. Plan/Group Number

17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above
 Self Spouse Dependent Child Other

19. Reserved For Future Use

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

21. Date of Birth (MM/DD/CCYY)

22. Gender
 M F U

23. Patient ID/Account # (Assigned by Dentist)

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 | 29a. Diag. Pointer | 29b. Qty. | 30. Description | 31. Fee |
|----|---------------------------------|-------------------------|------------------|----------------------------------|-------------------|--------------------|--------------------|-----------|-----------------|---------|
| 1 | | | | | | | | | | |
| 2 | | | | | | | | | | |
| 3 | | | | | | | | | | |
| 4 | | | | | | | | | | |
| 5 | | | | | | | | | | |
| 6 | | | | | | | | | | |
| 7 | | | | | | | | | | |
| 8 | | | | | | | | | | |
| 9 | | | | | | | | | | |
| 10 | | | | | | | | | | |

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier (ICD-10 = AB)

34a. Diagnosis Code(s) A _____ C _____
(Primary diagnosis in "A") B _____ D _____

31a. Other Fee(s)

32. Total Fee

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.

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

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 (all dates in MM/DD/CCYY format)

38. Place of Treatment (e.g. 11=office; 22=O/P Hospital)
(Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N)

39a. Date Last SRP

40. Is Treatment for Orthodontics?
 No (Skip 41-42) Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment 43. Replacement of Prosthesis
 No Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

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 _____
Signed (Treating Dentist) Date

53a. Locum Tenens Treating Dentist?

54. NPI

55. License Number

56. Address, City, State, Zip Code

56a. Provider Specialty Code

57. Phone Number () -

58. Additional Provider ID

Dental Claim Form Completion Instructions for Members

To file the claim:

1. Complete item numbers 1-2, 4-22 and 36-37 on the ADA form on the previous page
2. Attach a signed superbill or statement from your dentist
3. Mail completed form to:

**BlueCross BlueShield of Tennessee
Claims Service Center
1 Cameron Hill Circle Suite 0002
Chattanooga, TN 37402-0002**

Note: Save a copy of the completed claim form and superbill/statement for your records.

Header Information

The “header” gives information about the type of claim being filed.

| HEADER INFORMATION | |
|---|--|
| 1. Type of Transaction (Mark 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.** If services have been performed, check the “Statement of Actual Services” box. If you are requesting an estimate, check the Predetermination box. If the claim is through the Early and Periodic Screening, Diagnosis and Treatment Program, mark the box marked “EPSDT/Title XIX”
2. **Predetermination/Preauthorization Number.** If the services were previously approved, enter the predetermination claim number.

Insurance Company/Dental Benefit Plan Information

| DENTAL BENEFIT PLAN INFORMATION |
|--|
| 3. Company/Plan Name, Address, City, State, Zip Code |

3. **Name, Address, City, State, Zip Code.** This is for the insurance company/benefit plan information where you are sending the claim form. This field has already been populated with the BlueCross BlueShield of Tennessee address.

Other Coverage

This area of the claim form is for other dental or medical coverage information. This is needed to check for coordination of benefits.

| OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.) | | |
|---|---|--|
| 4. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (If both, complete 5-11 for dental only.) | | |
| 5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix) | | |
| 6. Date of Birth (MM/DD/CCYY) | 7. Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U | 8. Policyholder/Subscriber ID (Assigned by Plan) |
| 9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other | |
| 11. Other Insurance Company/Dental Benefit Plan 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 is other coverage for the patient, check the box marked "Yes" and complete Items #5 - 11.
- 5. Other Insured's Name (Last, First, Middle, Suffix).** Enter the name of the policyholder of the other insurance.
- 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 "F" for female or "U" for undisclosed.
- 8. Subscriber Identification Number.** Enter the ID number of the person who is listed in Item #5.
- 9. Plan/Group Number.** Enter the group number of the other policy.
- 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 other insurance information.

Policyholder/Subscriber Information

This section is for information about the insured person (policyholder/subscriber) who may or may not be the patient.

| POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan 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 <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U | 15. Policyholder/Subscriber ID (Assigned by Plan) |
| 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 “F” for female or “U” for undisclosed.
- 15. Subscriber Identification Number.** Enter the subscriber identification number of the primary insured. This number should be on the ID card.
- 16. Plan/Group Number.** Enter the primary insured’s group plan/policy number. This number should be on the ID card.
- 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 Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other | | 19. Reserved For Future Use |
| 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 <input type="checkbox"/> U | 23. Patient ID/Account # (Assigned by Dentist) |

- 18. Relationship to Primary Insured (Check applicable box).** Mark the appropriate box. If the patient is also the primary insured, mark the box titled “Self” and skip to Item #36.
- 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 and address 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 “F” for female or “U” for undisclosed.

Attach a signed superbill/statement from your dentist that reflects the treatment you received and skip to Item # 36.

Authorizations

This section gives consent for treatment. It also gives permission for the payer to send payment directly to the dentist.

| 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 or guardian must sign and date here. This signature confirms responsibility for treatment costs and is the release of information for the purpose of collecting payment.
- 37. Insured's Signature.** This is an authorization for payment of benefits to the dentist. Do not sign this block if the (out-of-network) dentist has been paid and the payment should go to the subscriber.
Note: In-network providers must file claims and will receive payment.

