

Dental Claim Form

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of Tennessee

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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

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/DENTAL BENEFIT PLAN INFORMATION
3. Company/Plan Name, Address, City, State, Zip Code
BlueCross BlueShield of Tennessee
Claims Service Center
1 Cameron Hill Circle Suite 0002
Chattanooga, TN 37402-0002

13. Date of Birth (MM/DD/CCYY) 14. Gender M F 15. Subscriber Identification Number
16. Plan/Group Number 17. Employer Name

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 M F 8. Subscriber Identification Number
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

PATIENT INFORMATION
18. Relationship to Policyholder/Subscriber in #12 Above
Self Spouse Dependent Child Other
19. Student Status FTS PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY) 22. Gender M F 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

Table with columns: 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

MISSING TEETH INFORMATION
34. (Place an 'X' on each missing tooth)
Permanent: 1-16, Primary: A-J, K-T
32. Other Fee(s) 33. 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

ANCILLARY CLAIM/TREATMENT INFORMATION
38. Place of Treatment Provider's Office Hospital ECF Other
39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)
40. Is Treatment for Orthodontics? No (Skip 41-42) Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining 43. Replacement of Prosthesis? No Yes (Complete 44)
44. Date 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

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

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
54. NPI 55. License Number
56. Address, City, State, Zip Code 56A. Provider Specialty Code
57. Phone Number () - 58. Additional Provider ID