

Dental Claim Form Completion Instructions for Members

To file the claim:

1. Complete item numbers 1-2, 4-22 and 36-37
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

INSURANCE COMPANY/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		
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> F	8. Subscriber Identification Number
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 or “F” for Female.
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 (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 <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. 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. 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).** 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 or “F” for female.

Attach a signed superbill/statement from your dentist that reflects the treatment you received and skip to Item # 36. (See page 4)

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 to go to the subscriber.
Note: In-network providers must file claims and will receive payment.

ADA American Dental Association® Dental Claim Form

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

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

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

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

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 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

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 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	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-9 = B; 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

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (e.g. 11=office; 22=O/P Hospital) 39. Enclosures (Y or N)

(Use "Place of Service Codes for Professional Claims")

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 44. Date of 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

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

ADA American Dental Association®

America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

GENERAL INSTRUCTIONS

- A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.
- B. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.
- C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.
- D. All dates must include the four-digit year.
- E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35). There are additional detailed completion instructions in the CDT manual.

DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

- Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)
- Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)
- Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

- 11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf

PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Provider taxonomy codes listed above are a subset of the full code set that is posted at www.wpc-edi.com/codes/taxonomy