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.

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**Header Information**

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

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.

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**Insurance Company/Dental Benefit Plan Information**

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.

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.

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

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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.

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**Patient Information**

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

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**PATIENT INFORMATION**

<table>
<thead>
<tr>
<th>18. Relationship to Policyholder/Subscriber in #12 Above</th>
<th>19. Student Status</th>
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<tbody>
<tr>
<td>[ ] Self</td>
<td>[ ] FTS</td>
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<tr>
<td>[ ] Spouse</td>
<td>[ ] PTS</td>
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<tr>
<td>[ ] Dependent Child</td>
<td>[ ] Other</td>
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</tbody>
</table>

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.

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**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.

<table>
<thead>
<tr>
<th>AUTHORIZATIONS</th>
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<tr>
<td>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 a 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.</td>
</tr>
<tr>
<td>X Patient/Guardian signature Date</td>
</tr>
<tr>
<td>37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.</td>
</tr>
<tr>
<td>X Subscriber signature Date</td>
</tr>
</tbody>
</table>

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.
**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

**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

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

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**

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix)

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

14. Gender

15. Subscriber Identification Number

16. Plan/Group Number

17. Employer Name

**POLICYHOLDER/SUBSCRIBER INFORMATION**

18. Relationship to Policyholder/Subscriber in #12 Above

19. Student Status

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)

**RECORD OF SERVICES PROVIDED**

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**MISSING TEETH INFORMATION**

34. (Place an 'X' on each missing tooth)

35. Remarks

**AUTHORIZATIONS**

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all changes due to fees or materials not paid by my 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 changes. 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.

 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.

 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

**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
   - No
   - Yes (Complete 44)

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

**TREATING DENTIST AND TREATMENT LOCATION INFORMATION**

52. Phone Number ( )

53. Additional Provider ID

54. NPI

55. License Number

56. Address, City, State, Zip Code

58A. Provider Specialty Code

57. Phone Number ( )

58. Additional Provider ID

**Dental Claim Form 01.2008**