Dental Claim Form Completion Instructions for Members

To file the claim:

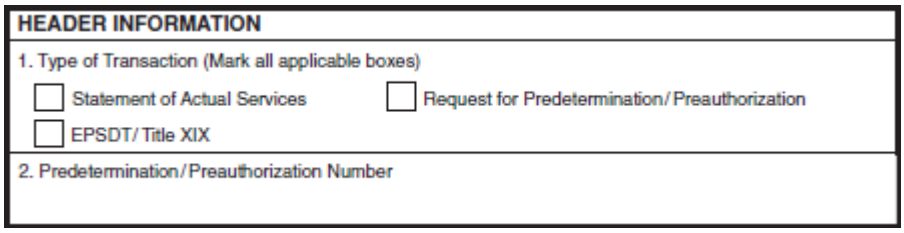
1. Complete item numbers **1-2, 4-22** and **36-37**
2. Attach a signed superbill or statement from your dentist
3. Mail completed form to:

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.

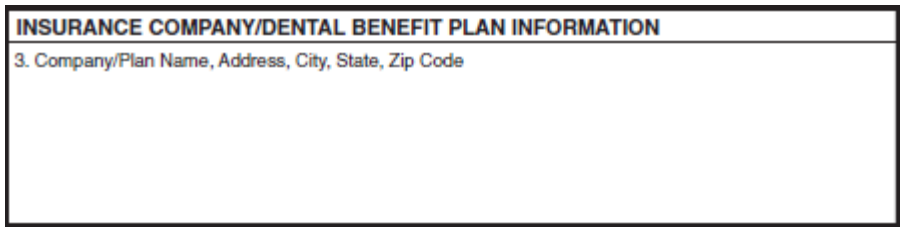
Header Information

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



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 **E**arly and **P**eriodic **S**creening, **D**iagnosis and **T**reatment Program, mark the box marked "EPSDT/Title XIX"
2. **Predetermination/Preauthorization Number.** If the services were previously approved, enter the predetermination claim number.

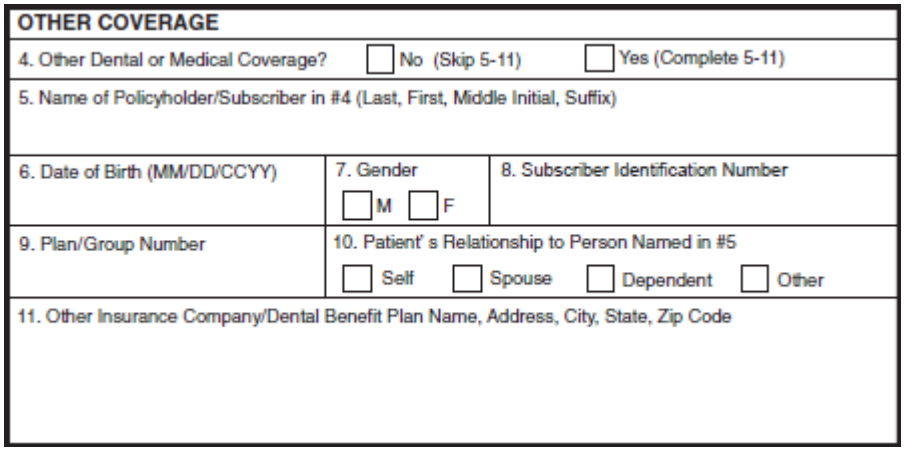
Insurance Company/Dental Benefit Plan Information



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.

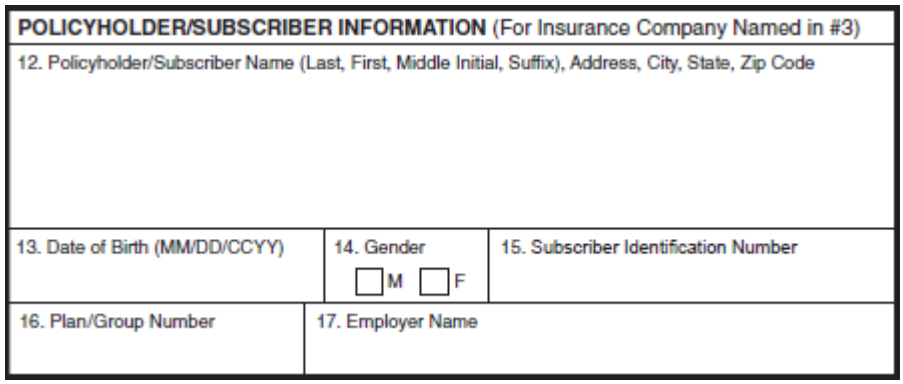


OTHER COVERAGE		
4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)		
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		
6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Subscriber Identification Number
9. Plan/Group Number	10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code		

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.

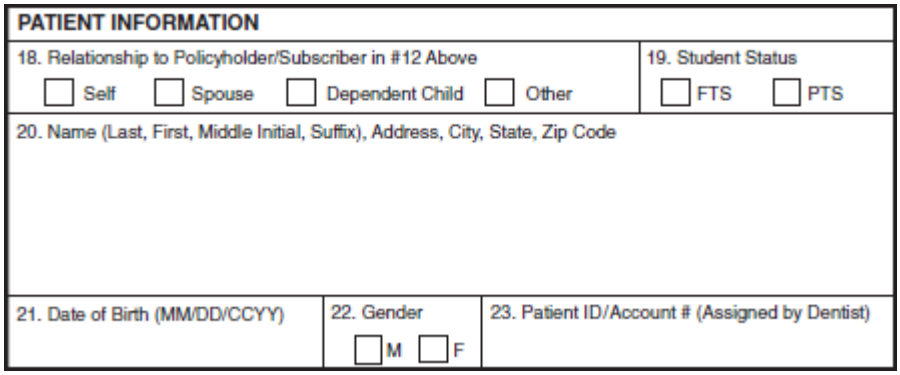


POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)		
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code		
13. Date of Birth (MM/DD/CCYY)	14. Gender ☐ M ☐ F	15. Subscriber Identification Number
16. Plan/Group Number	17. Employer 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.



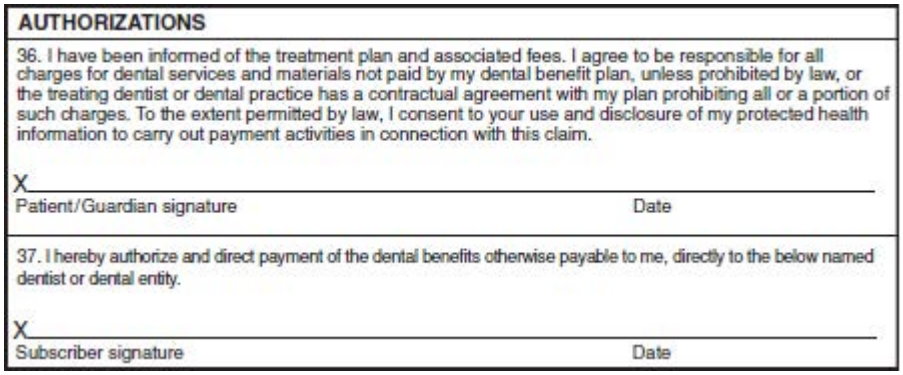
PATIENT INFORMATION		
18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other		19. Student Status ☐ FTS ☐ PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code		
21. Date of Birth (MM/DD/CCYY)	22. Gender ☐ M ☐ F	23. Patient ID/Account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

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.

Dental Claim Form -- Confidential --

of Tennessee
plans for better health. plans for a better life.™

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association
®Registered Marks of the BlueCross BlueShield Association, an Association of Independent BlueCross BlueShield Plans

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

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

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 ☐ M ☐ F | 15. Subscriber Identification Number

16. Plan/Group Number | 17. Employer Name

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

	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
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

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

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	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