

DENTAL CLAIM FORM

Blue Shield of California and Blue Shield of California Life & Health Insurance Company

Submit Dental Claims To: Blue Shield, P.O. Box 272590, Chico, CA 95927-2590

Blue Shield Use Only	IMPORTANT: Treatment plans exceeding \$250.00 should be submitted for precertification. Failure to do so may result in patient responsibility for claims subsequently adjusted or denied.
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Patient/subscriber information

1. Patient Name		2. Relationship To Employee <small>Self Spouse/Domestic Partner Child Other</small>		3. Sex <small>M F</small>	4. Patient Birthdate <small>Month Day Year</small>	5. If Full Time Student <small>School City</small>
6. Employee/Subscriber Name <small>First Initial Last</small>		7. Employee/Subscriber No. (see dental ID card)				
8. Mailing Address, Street, City, State, Zip Code		9-12. Employee/Subscriber Group No. and/or Group Name				
13. Are other family members employed?	Employee Name	Soc. Sec. No	14. Name and address of employer in Item 13			
15. Is patient covered by another dental plan?	Dental Plan Name	Union Local	Policy No.	Name and Address of Carrier		

Dentist information

16. Dentist SS# or T.I.N.	17. Dentist license no.	18. Dentist phone no.	19. Dentist's name, address, city, state, Zip Code			
20. Provider ID						
21. First visit date of current series	22. Place of treatment <small>Office Hospital ECF Other</small>	23. Radiographs or models enclosed? <small>Yes No How many?</small>	27. If Prosthesis/crown is this initial placement? <small>Yes No</small>	If No, the reason for replacement	28. Date of prior placement	
24. Is treatment result of occupation illness or injury? <small>Yes No</small>	If yes, enter brief description and dates		29. Is treatment for orthodontics? <small>Yes No</small>	If services already commenced enter: <small>Date appliances placed Months of treatment remaining</small>		
25. Is treatment result of auto accident? <small>Yes No</small>			I hereby certify that the services listed have been or will be provided by me. <small>Dentist's Signature Date</small>			
26. Other accident? <small>Yes No</small>						

30. Examination and treatment plan List in order from tooth no. 1 Through tooth no. 32

Identify missing teeth with "X" FACIAL	Tooth No. or letter	Surface	Description of Service <small>(Including x-rays, prophylaxis, materials used etc.)</small>	Date Service Performed			ADA Procedure Number	Fee	Blue Shield use only Allowed Amount	
				MO	DAY	YEAR				
		Total Fee Actually Charged								
Remarks:										

31. Patients Authorization: I have been informed of the treatment plan and associated fees identified above, and, to the extent permitted by law, I authorize the release of information relative to this course of treatment and to the payment activities in connection with this claim. 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. I understand that I am responsible for the charges for any service not approved by benefit pre-certification review, or are rendered during any ineligible period and for the co-payments, deductibles and amounts exceeding the calendar year maximum of my dental plan. I understand that I may request a copy of any precertification review determination from Blue Shield.

Signed (Patient or Guardian if Minor) _____ Date _____

32. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the above named dentist or dental entity.

Subscriber/Member Signature _____ Date _____