

Dental Claim Form

-- Confidential --



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
15. Subscriber Identification Number
16. Plan/Group Number
17. Employer Name

OTHER COVERAGE
4. Other Dental or Medical Coverage?
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender
8. Subscriber Identification Number
9. Plan/Group Number
10. Patient's Relationship to Person Named in #5
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

PATIENT 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

Table with 10 rows and 10 columns: 24. Procedure Date, 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)
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.
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

ANCILLARY CLAIM/TREATMENT INFORMATION
38. Place of Treatment
39. Number of Enclosures (00 to 99)
40. Is Treatment for Orthodontics?
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis?
44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from
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.
54. NPI
55. License Number
56. Address, City, State, Zip Code
56A. Provider Specialty Code
57. Phone Number
58. Additional Provider ID