Empire BlueCross BlueShield

DENTAL CLAIM FORM

1. CHECK ONE (✓)
   - ❑ DENTIST FEE TREATMENT ESTIMATE
   - ❑ DENTIST STATEMENT OF ACTUAL SERVICES

2. PRIOR AUTHORIZATION NO.
   PATIENT ID NO.

3. CARRIER NAME AND ADDRESS
   EMPIRE BLUECROSS BLUESHIELD
   DENTAL BENEFITS PROGRAMS
   P.O. BOX 791
   MINNEAPOLIS, MN 55440-0791

PATIENT COVERAGE INFORMATION

4. PATIENT NAME

5. RELATIONSHIP TO EMPLOYEE
   ❑ SELF ❑ DAUGHTER
   ❑ SPOUSE ❑ SON
   ❑ OTHER _____

6. SEX
   ❑ M ❑ F

7. PATIENT BIRTH DATE
   MONTH DAY YEAR

8. IF FULL TIME STUDENT
   SCHOOL CITY

9. EMPLOYEE/SUBSCRIBER NAME AND ADDRESS

10. EMPLOYEE/SUBSCRIBER IDENTIFICATION NUMBER

11. EMPLOYEE/SUBSCRIBER BIRTH DATE
    MONTH DAY YEAR

12. GROUP NUMBER

13. EMPLOYER NAME AND ADDRESS

14. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ❑ YES ❑ NO - **IF YES, COMPLETE 15-18**
    IS PATIENT COVERED BY A MEDICAL PLAN?
    ❑ YES ❑ NO

15-A. NAME AND ADDRESS OF OTHER CARRIER(S)

15-B. GROUP NUMBER(S)

16. OTHER PLAN-EMPLOYER NAME/ADDRESS

17-A. OTHER PLAN - SUBSCRIBER NAME
(IF DIFFERENT FROM PATIENT(S))

17-B. OTHER PLAN-SUBSCRIBER IDENTIFICATION NUMBER

17-C. SUBSCRIBER BIRTH DATE
MONTH DAY YEAR

18. RELATIONSHIP TO PATIENT
    ❑ SELF ❑ DAUGHTER
    ❑ SPOUSE ❑ SON
    ❑ OTHER _____

19. I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN AND FEES. I AGREE TO BE RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT. I AUTHORIZE RELEASE OF ANY INFORMATION RELATED TO THIS CLAIM.

PATIENT SIGNATURE DATE

20. I HEREBY AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THE BELOW NAMED DENTIST ENTITY.

SIGNATURE (EMPLOYEE/SUBSCRIBER) DATE

BILLING DENTIST COMPLETES

21. NAME OF BILLING DENTIST OR DENTAL ENTITY

22. ADDRESS WHERE PAYMENT SHOULD BE REMITTED

23. CITY, STATE, ZIP

24. DENTIST SSN OR TIN

25. DENTIST LICENSE NO.

26. PHONE NUMBER

27. 1ST VISIT

28. PLACE OF TX
    OFF ❑ HOSPITAL ❑
    ECF ❑ OTHER ❑

29. RADIOGRAPHS OR MODELS ENCLOSED? NO YES HOW MANY?

30. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? NO YES IF YES, ENTER DESCRIPTION AND DATE

31. IS TREATMENT RESULT OF AUTO ACCIDENT? NO YES

32. OTHER ACCIDENT? NO YES

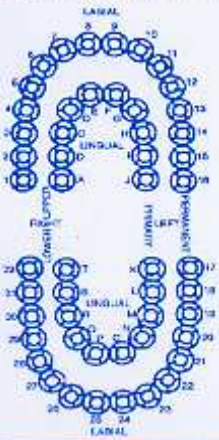
33. IF PROSTHESIS, IS IT INITIAL PLACEMENT? NO YES IF NO, REASON FOR REPLACEMENT

34. DATE OF PRIOR PLACEMENT

35. IS TREATMENT FOR ORTHODONTICS? NO YES DATE APPLIANCES PLACED?

MISC. TREATMENT REMAINING?

36. IDENTIFY MISSING TEETH WITH 'X'



37. EXAMINATION AND TREATMENT PLAN

TOOTH	SURF	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, ETC.)	DATE OF SERVICE MO	DAY	YEAR	PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY

38. REMARKS FOR UNUSUAL SERVICES

39. I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THAT THE FEES SUBMITTED ARE THE ACTUAL FEES I HAVE CHARGED AND INTEND TO COLLECT FOR THOSE PROCEDURES.

SIGNED (TREATING DENTIST) LICENSE NUMBER DATE

40. ADDRESS WHERE TREATMENT WAS PERFORMED

CITY STATE ZIP CODE

41. TOTAL FEE CHARGED

42. PAYMENT BY OTHER PLAN

MAX ALLOWABLE

DEDUCTIBLE

CARRIER %

PATIENT PAYS