

# Dental Claim Form



**Arkansas  
BlueCross BlueShield**  
An Independent Licensee of the Blue Cross and Blue Shield Association

## 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

## 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    8. Policyholder/Subscriber ID (SSN or ID#)

M     F

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    15. Policyholder/Subscriber ID (SSN or ID#)

M     F

16. Plan/Group Number    17. Employer Name

## PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above    19. Student Status

Self     Spouse     Dependent Child     Other     FTS     PTS

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)

M     F

## 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)	33. Total Fee
	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		
																	T	S	R	Q	P	O	N	M	L	K		

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. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

X \_\_\_\_\_ Date  
Patient / Guardian signature

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 \_\_\_\_\_ Date  
Subscriber signature

## 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

## ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment    39. Number of Enclosures (00 to 99)

Provider's Office     Hospital     ECF     Other    Radiograph(s)    Oral Image(s)    Model(s)

40. Is Treatment for Orthodontics?    41. Date Appliance Placed (MM/DD/CCYY)

No (Skip 41-42)     Yes (Complete 41-42)

42. Months of Treatment Remaining    43. Replacement of Prosthesis?    44. Date Prior Placement (MM/DD/CCYY)

No     Yes (Complete 44)

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

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 \_\_\_\_\_ Date  
Signed (Treating Dentist)

54. NPI    55. License Number

56. Address, City, State, Zip Code    56A. Provider Specialty Code

57. Phone Number ( ) -    58. Additional Provider ID

## HOW TO FILE A CLAIM

1. Complete boxes 1 – 23.
2. Please make sure box 15 contains your member number as it appears on your ID card. **Do not use your social security number in this box.**
3. Be sure to sign the authorization to release information in box 36.
4. Ask your dentist to complete boxes 24 – 58, or attach an original itemized billing from the dentist on his/her letterhead or approved ADA claim form that includes all information requested in boxes 24-58.
5. Attach all related Explanation of Benefits statements for other coverage if applicable.
6. Send completed claim form to:

Dental Claims Administrator  
PO Box 69436  
Harrisburg, PA 17106-9436

NOTE: Subscriber submitted claim forms must be submitted within 180 days of the date of service. Claims which cannot be identified due to incomplete subscriber information will be returned.

## HOW TO REACH US

Phone:                   • Members - (888) 223-4999  
                              • Providers - (888) 224-5213

Write:                   Dental Customer Service  
                              PO Box 69437  
                              Harrisburg, PA 17106-9437