Dental Claim Form

HEADER INFORMATION															
Type of Transaction (Mark all ap)	Arkansas														
Statement of Actual Services	BlueCross Blu	ueShi	eld												
EPSDT/Title XIX	An Independent Licensee of the Blue Cross and Blue Shield Association														
Predetermination/Preauthorizati	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/DEN	NTAL BEN	EFIT PI	AN INFOR	RMATION											
3. Company/Plan Name, Address, 0			-AIT IITI OI	IIIIAIIOII											
															- 1
	13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscriber ID (SSN or ID#)						#)								
				М	F										
OTHER COVERAGE		16. Plan/Group Number	11	7. Employer	Name										
4. Other Dental or Medical Coveraç	Yes (
5. Name of Policyholder/Subscribe	PATIENT INFORMATION														
		18. Relationship to Policyholder/Subscriber in #12 Above 19. Student Status													
6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyhole				nolder/Sub	scriber ID (SSN	or ID#)	Self Spouse Dependent Child Other FTS P							PTS	3
							20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code								
9. Plan/Group Number	10. Patie	ent's Rel	ationship to I	Person Nar	ned in #5										
	Se	elf	Spouse	Depe	endent O	ther									
11. Other Insurance Company/Den	ital Benefit P	lan Nam	e, Address, C	ity, State,	Zip Code										
															- 1
							21. Date of Birth (MM/DD/C	CYY)	22. Gender		23. Patient ID	/Account # (Assign	gned b	y Den	itist)
									M	F					- 1
RECORD OF SERVICES PRO	OVIDED									•					
	Area 26.	27	. Tooth Numb	er(s)	28. Tooth	29. Procedu	ıre						Ι.		
	Oral Tooth System	all 100th or Lottor(c)			Surface Code				30. Descripti	on			3	31. Fee	е
1															
2															
3															
4															
5															
6															
7															
8															
9															
10															
MISSING TEETH INFORMATI	ION				Permanent				Primary			32. Other			
	1	2 3	3 4 5	6 7	8 9 10	11 12	13 14 15 16 A B	B C D	EF	G	H I J	Fee(s)			
34. (Place an 'X' on each missing to	ooth) 32	31 3	0 29 28	27 26	25 24 23	22 21	20 19 18 17 T S	B R G	P O	N	M L K	33.Total Fee	1		
35. Remarks	'				<u>'</u>		<u>'</u>		<u> </u>						
AUTHORIZATIONS							ANCILLARY CLAIM/TF	REATME	NT INFORI	MATIO	N N				\neg
36. I have been informed of the treatment			38. Place of Treatment 39. Number of Enclosures (00 to 99)												
charges for dental services and ma the treating dentist or dental praction	efit plan, un th mv plan	Radiograph(s) Oral Image(s) Model(s) Provider's Office Hospital ECF Other													
such charges. To the extent permiti															
a false or fraudulent claim for paymapplication for insurance is guilty of	No (Skip 41-42) Yes (Complete 41-42)														
X		<u> </u>	ement of Pro		2 44. Date F	Prior Placement (MM/D	D/CCY	(Y)						
Patient / Guardian signature	Remaining	No [Yes (Comp			(,						
 I hereby authorize and direct paym dentist or dental entity. 	45. Treatment Resulting from								-						
defined of definal entity.	Occupational illness/injury Auto accident Other accident														
XSubscriber signature	46. Date of Accident (MM/D			4001		47. Auto Accide		te	\dashv						
							`		ATMENT		ON INFOR		Old		\dashv
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)							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								
48. Name, Address, City, State, Zip	visits) or have been complete			, aato a	progress (p. 0000da160 (116	oqui	. o muli							
70. Ivaine, Audress, Oily, State, Zip	JOULE														
	X								— I						
	54. NPI 55. License Number 56. Address, City, State, Zip Code 56A. Provider														
40 NDI	Jo. Address, Oily, State, Zif	h coae	L	Specia	Ity Code										
49. NPI	50. License	Number		51. SSN	UI I IIN										
52. Phone			52A. Additio	nal			57. Phone		Т	58. Add	litional				
Number ()	-		Provid	ler ID			Number ()	-		Pro	vider ID				- 1

HOW TO FILE A CLAIM

- 1. Complete boxes 1 23.
- 2. Please make sure box 15 contains your member number <u>as it appears on your ID card</u>. **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