

**Dental Claim Form**

See reverse for instructions

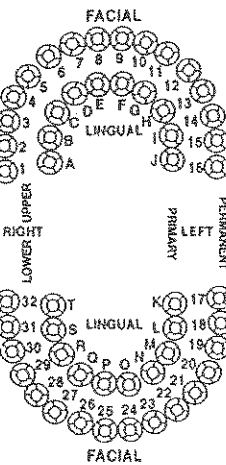
<p>1 <input type="checkbox"/> Dentist's pre-treatment estimate <input type="checkbox"/> Dentist's statement of actual services Provider ID#</p>	<p>2 <input type="checkbox"/> Medical Claim <input type="checkbox"/> EPSDT Prior Authorization # Patient ID #</p>	<p>3. Carrier name and address</p>
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P A T I E N T S  C O V E R A G E  I N F O R M A T I O N	<p>4. Patient name first m.l. last</p>	<p>5. Relationship to employee <input type="checkbox"/> self    <input type="checkbox"/> child <input type="checkbox"/> spouse   <input type="checkbox"/> other</p>	<p>6. Sex m   f</p>	<p>7. Patient birthdate MM DD YYYY</p>	<p>8. If full time student school  city</p>
	<p>9. Employee/subscriber name and mailing address</p>	<p>10. Employee/subscriber dental plan I.D. number</p>	<p>11. Employee/subscriber birthdate MM DD YYYY</p>	<p>12. Employer (company) name and address</p>	<p>13. Group number</p>
	<p>14. Is patient covered by another dental plan? yes    no If yes, complete 15-a Is patient covered by a medical plan? yes    no</p>	<p>15-a. Name and address of carrier(s)</p>	<p>15-b. Group no.(s)</p>	<p>16 Name and address of other employer(s)</p>	
<p>17-a. Employee/subscriber name (if different from patient's)</p>	<p>17-b. Employee/subscriber dental plan I.D. number</p>	<p>17-c. Employee/subscriber birthdate MM DD YYYY</p>	<p>18. Relationship to patient <input type="checkbox"/> self    <input type="checkbox"/> parent <input type="checkbox"/> spouse   <input type="checkbox"/> other</p>		

19. I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless 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 under applicable law, I authorize release of any information relating to this claim.

20. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity:

Signed (Patient* - see reverse) _____ Date _____	Signed (Employee/subscriber) _____ Date _____
<p>21. Name of Billing Dentist or Dental Entity</p> <p>22. Address where payment should be remitted</p> <p>23. City, State, Zip</p> <p>24. Dentist Soc. Sec. or T.I.N. (see reverse")</p> <p>25. Dentist license no.</p> <p>26. Dentist phone no.</p> <p>27. First visit date current series</p> <p>28. Place of treatment Office   Hosp.   ECF   Other</p> <p>29. Radiographs or models enclosed?   No   Yes   How many?</p>	<p>30. Is treatment result of occupational illness or injury?   No   Yes   If yes, enter brief description and dates.</p> <p>31. Is treatment result of auto accident?</p> <p>32. Other accident?</p> <p>33. If prosthesis, is this initial placement?   (If no, reason for replacement)</p> <p>34. Date of prior placement</p> <p>35. Is treatment for orthodontics?   If service already commenced enter:   Date appliance placed   Mos. treatment remaining</p>

36. Identify missing teeth with "x"	37. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Using charting system shown.							For Administrative use only
	Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year	Procedure number	Fee		

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.	41. Total Fee Charged	
Signed (Treating Dentist) _____ License Number _____ Date _____	42. Payment by other plan	
	Max. Allowable	
	Deductible	
	Carrier %	
	Carrier Pays	
40. Address where treatment was performed	Patient Pays	
City _____ State _____ Zip _____		

Return to:  
BlueShield of Northeastern NY  
PO Box 80  
Buffalo, NY 14240-0080

The following is an item-by-item description of the questions appearing on the new form. All questions in the Billing Dentist Section should be answered as completely as possible to facilitate prompt and accurate reimbursement and to reduce follow-up inquiries. Special completion and mailing instructions, which may vary from company to company, will be printed on the form and will not be addressed here.

1. **Dentist's pretreatment estimate or statement of actual services:** By checking the appropriate box, the form may be processed more quickly and with less chance of error.
2. **Provider identification number:** Some third-party payers use an I.D. number that is different from the T.I.N. or license number.
3. **Medicaid claim, EPSDT, prior authorization number, patient I.D. number:** Include appropriate information for government funded benefit programs as necessary.
3. **Carrier name and address:** The name and address of the carrier where the claim is to be sent. On carrier-supplied claim forms, this information ordinarily will be preprinted at the top of the form.
4. **Patient name:** This should be completed in full for proper identification purposes.
5. **Relationship to employee:** Employee here refers to the insured person and his or her relationship to the patient. This relationship sometimes affects the patient's eligibility, as well as level of benefits available.
6. **Sex:** This is requested for identification purposes and for statistical analysis.
7. **Patient birthdate:** Very important for determination of eligibility.
8. **If full-time student:** Eligibility of the dependent patient may be affected if the patient is over a certain age (specified in the benefits policy) and is still a full-time student.
9. **Employee/subscriber name and address:** Refers to the insured person and is not necessarily the patient.
10. **Employee/subscriber dental plan I.D. number:** If you do not know your dental plan ID# contact your dental plan. Your social security number (SSN) is commonly used for computer and manual processing of claims, but some carriers use an identification number that is different from the SSN.
11. **Employee/subscriber birthday:** Very important for determination of coordination of benefits.
12. **Employer (company) name and address:** Refers to employer of person in #8.
13. **Group number:** Refers to master contract policy number assigned to the employer group.
14. **Is patient covered by another dental plan? or is patient covered by a medical plan?:** This is to determine multiple coverage. The information contained in items 14 - 18 is very important in order to determine which other carriers, if any, have primary liability for treatment provided.
- 15a. **Name and address of carrier(s):** Refers to carrier(s) in #14.
- 15b. **Group number:** Refers to #14.
16. **Name and address of other employer(s):** Refers to employer offering plan in #14.
- 17a. **Employee/subscriber name (if different from patient's):** Refers to employee from #16.
- 17b. **Employee/subscriber dental plan I.D. number:** Refers to employer in #17a. If you do not know your dental plan ID# contact your dental plan. Your social security number (SSN) is commonly used for computer and manual processing of claims, but some carriers use an identification number that is different from the SSN.
- 17c. **Employee/subscriber birthdate:** Refers to employee in #17a. Necessary for coordination of benefits.
18. **Relationship to patient:** Refers to employee in #17a.
19. **Patient signature block:** The patient is defined as an individual who has established a professional relationship with a dentist for the delivery of dental health care. For matters relating to communication of information and consent, this term includes the patient's parent, caretaker guardian, or other individual as appropriate under state law in the circumstances of the case.
20. **Employee/subscriber block:** This block must be completed if the patient and/or the dentist wish to have benefits paid directly to the provider. This is an authorization of payment and does not constitute an assignment of benefits. It does not create a contractual relationship between the dentist and the payer.
21. **Name of Billing Dentist, or Dental Entity:** The individual dentist's name or the name of the group practice/corporation responsible for billing. This may differ from the actual treating dentist's name. This is the name that should appear on any payments or correspondence that will be remitted to the billing dentist.
22. **Address where payment should be remitted:** Self explanatory.
23. **City, state, zip:** self explanatory.
24. **Dentist's social security number or T.I.N.:** Refers to dentist or dental entity in #21. These numbers are frequently used as individual provider identification numbers. The Internal Revenue Service requires that either the social security or tax payer identification number of the billing dentist or dental entity be supplied only if the provider accepts payment directly from a third-party payer. Report the SS# if the billing dentist is unincorporated. Report the corporation T.I.N. if the billing dentist is incorporated. If the billing entity is a group practice, clinic, etc., the entity's T.I.N. should be entered.
25. **Dentist's license number:** Frequently used as a means of provider identification. This should be the license number of the billing dentist. This may differ from that of the treating dentist, which appears in the Dentist's signature block at the bottom of the form.
26. **Dentist's phone number:** Self explanatory. Include area code also.
27. **First visit date current series:** Important to determine what services are covered when a patient becomes eligible in the middle of an active treatment plan.
28. **Place of treatment:** Depending on where treatment is rendered, medical and/or hospital coverage including dental benefits may be activated. ECF stands for "extended care facility".
29. **Radiographs or models enclosed:** Indicates whether diagnostic materials were submitted. Assists in return of proper number of materials to dentist.
30. **Is treatment result of occupational illness or injury?:** Refers to possible application of Workers Compensation, which would alter coverage available and carrier involved. Important for coordination of benefits, and accurate claims processing.
31. **Is treatment result of auto accident?:** Will affect reimbursement in no-fault auto cases. Indicates whether another party's insurance may be responsible. Also important for coordination of benefits.
32. **Other accident?:** Similar to #30 and #31.
33. **If prosthesis, is this initial placement?:** Most dental contracts have specific limitations on replacement of dentures, partials, crowns, and bridges. This is used to determine eligibility and liability.
34. **Date of prior placement:** Contracts specify time limitations concerning the replacement of prosthetic devices.
35. **Is treatment for orthodontics?:** When orthodontics are covered, dates and months of treatment remaining will affect the prorated monthly reimbursement made to the dentist.
36. **Identify missing teeth with "x":** Self explanatory.
37. **Examination and treatment plan:** Self explanatory. Use the American Dental Association's Current Dental Terminology (CDT-2) for appropriate procedure codes.
38. **Remarks for unusual services:** Use to indicate any information which you feel may be helpful in determining the benefits for the treatment. If space is inadequate, utilize unused portion of #37, or attach a separate sheet.
39. **Dentist's signature block:** The treating dentist's signature and license number.
40. **Address where treatment was performed:** Complete this section if the treatment was performed at a different location than indicated in #22 and #23.
41. **Total fee charged:** Sum of the fees for each procedure reported.
42. **Payment by other plan:** If known, indicate the dollar amount paid by other benefit plan(s).

**For administrative use only:** Area where carrier calculates benefits.

**Payment itemization:** The spaces under "payment by other plan" will be completed by the carrier and may vary from carrier to carrier.