

Excellus BlueCross BlueShield Mail Completed Forms To: BlueCross BlueShield Association PO Box 22999 Rochester, NY 14692 Non-Participating ☐ Statement of Actual Services Pre-Determination of Benefits **Dental Claim Form** 7. Subscriber Identification number (including ID prefix): Part I - Subscriber/Patient Information Subscriber's 8. Is the patient covered by another dental plan? No (You are declaring that these services are not reimbursable under any other dental plan) Full Name Yes (Please complete the following section and, if appropriate, include your Explanation of Benefits) Date of Birth Subscriber's Name Address Subscriber Identification Number City, State, Zip Code ls this a new address? ☐ Yes ☐ No Name of Subscriber's Employer 2. Subscriber Hire Date 1. Subscriber Birthdate Name of Other Dental Plan 3. Patient Name 9. For services rendered out-of-area, I hereby authorize payment directly to the below named dentist of the group insurance benefits 4. Date of Birth Relationship to Subscriber otherwise payable to me. College Student Mo Day Self Husband Wife Daughter 6. I have reviewed the treatment plan. I authorize release of any information relating to the claim Date Subscriber's signature Signed (patient, or parent if minor) Date Is treatment result of: No Yes If yes, enter brief description and dates: Part II - Dentist Information 17. Occupational illnes or injury? 10. Dentist Name and 11. Mailing Address (city, state, zip) 18. Auto Accident? 19. Other accident? 20. Are any services If yes, enter name of other plan: covered by another plan? 21. Has the patient If yes, reason for replacement: Date of prior placement ever had a previous prosthesis; fixed [12. Social Security or T.I.N. 13. License Number or removable 2? If services already commenced enter: Total fee Date Months of orthodontics? 15. First visit date, current series Mo Day Yr 14. Phone Number 16. Radiographs or appliances placed treatment models enclosed? remaining YES NO ADA Tooth Indicate missing teeth with an "X" Date service procedure number Description of service number Surfaces performed or lette RIGHT Total fee actually charged Remarks for unusual services

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals information concerning any fact material thereto, for the purpose of misleading, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each violation.

I certify that the procedures as indicated by date, have been completed, personally supervised or rendered by me the attending dentist, that the fees submitted are actual fees I have charged and intended to collect.

Dentist signature:

Date:

INSTRUCTIONS

If dental care is rendered by a dentist who has an agreement with BlueShield, the dentist will have a supply of claim forms in the office, will file claims and will receive payment directly from BlueShield.

If care is rendered by a dentist who does **not** have an agreement with BlueShield, payment for covered services will be made directly to the subscriber. In this case, it is the subscriber's responsibility to make payment arrangements with the dentist.

If the dentist practices outside of the Excellus BlueCross BlueShield operating area and the subscriber wishes direct payment to the dentist, Field 9 on this claim form must be signed and dated by the subscriber.

<u>Pre-Determination of Benefits</u> - A standard component of dental insurance programs is the Pre-Determination of benefits process. By checking the Pre-Determination box at the top of the claim form, and leaving the date of service blank, an estimate of the benefits allowable under the terms of the subscriber's contract can be made before services are rendered. In some cases, not all of the services in the dentist's treatment plan will be covered. **Allowed benefits do not infer disagreement with the treatment plan**, but merely contract limitations. The Pre-Determination is valid for 12 months from the date of issue.

It is the subscriber's responsibility to complete PART I of this claim form.

PART I

KEY TO SUBSCRIBER/PATIENT INFORMATION FIELDS:

Subscriber's Full Name, Address, City, State, Zip Code REQUIRED (Unless pre-printed)

Field Number and Description:

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12	Subscriber Birthdate/Hire Date	OPTIONAL		
3.	Patient Name	REQUIRED		
45	Patient Date of Birth/Relationship to Subscri	per REQUIRED		
6.	Patient/Subscriber Signature/Date	OPTIONAL		
7.	Subscriber Identification Number	REQUIRED		
8.	Other Insurance Information*	REQUIRED		
9.	Out-of-Area Payment Authorization	WHEN APPLICABLE		

^{*}Coordination of Benefits - It is not unusual to be covered by two insurance policies providing similar benefits. When this is the case, we will coordinate benefit payments with the other carrier. This prevents duplicate payments and overpayments. Field 8 must be answered or the claim form will be returned to the subscriber for the information before payment can be made.

PART II

KEY TO DENTIST INFORMATION FIELDS:

Field Number and Description:			
1011. Dentist Name/Mailing Address	REQUIRED		
12. Social Security or T.I.N.	WHEN APPLICABLE		
13. License Number	OPTIONAL		
14. Phone Number	OPTIONAL		
15. First Visit Date, Current Series	WHEN APPLICABLE		
16. Radiographs or Models Enclosed?	WHEN APPLICABLE		
1719. Is Treatment Result of:	WHEN APPLICABLE		
20. Other Plan Coverage?	WHEN APPLICABLE		
21. Previous Prosthesis Information	WHEN APPLICABLE		
22. Is Treatment for Orthodontics?	WHEN APPLICABLE		
- Tooth Number or Letter	WHEN APPLICABLE		
- Surfaces	WHEN APPLICABLE		
- Description of Service	REQUIRED		
- Date Service Performed	WHEN APPLICABLE		
- ADA Procedure Number	REQUIRED		
- Fee	REQUIRED		
- Dentist Signature and Date	REQUIRED		

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PO Box 22999 Rochester, NY 14692

A separate claim form must be completed for each family member. If the claim form is not completed by both the subscriber and the dentist, the required information will be requested. This will delay processing of the claim. If you need assistance to complete this form or require additional forms. . . .

<u>SUBSCRIBERS and DENTISTS</u>: Please call our Dental Service Representative at: regarding Rochester subscribers, 1-800-724-1675; regarding CNY and CNY Southern Tier subscribers, 1-800-233-0384

TTY FOR THE HEARING IMPAIRED: Rochester 585-454-2845 CNY and CNY Southern Tier 315-448-6764