# Dental Claim Form

**Statement of Actual Services**

1. **PATIENT NAME**  
2. **RELATIONSHIP TO ENROLLEE**  
3. **GENDER**  
4. **PATIENT BIRTH DATE**
   - mm  
   - dd  
   - yy

5. **EMPLOYEE/ENROLLEE (First, Middle Last)**

6. **ENROLLEE ID. NO.**

7. **EMPLOYEE BIRTH DATE**
   - mm  
   - dd  
   - yy

8. **EMPLOYEE MAILING ADDRESS**

9. **EMPLORER (COMPANY)**

10. **GROUP #**

12. **IS PATIENT COVERED BY ANOTHER DENTAL PLAN?**
   - Yes
   - No

14. **MAILING ADDRESS**

15. **CITY, STATE, ZIP**

16. **DENTIST SSN OR TIN**

17. **DENTIST LICENSE #**

18. **DENTIST PHONE #**

19. **FIRST VISIT DATE CURRENT SERIES**
   - Office  
   - Hospital  
   - Other

20. **PLACE OF TREATMENT**

21. **RADIOGRAPHS OR MODELS ENCLOSED?**
   - Yes
   - No

23. **IS TREATMENT RESULT OF AUTO ACCIDENT?**

25. **IF PROSTHESIS, IS THIS INITIAL PLACEMENT?**
   - if services already commenced, enter
   - DATE APPLIANCES PLACED
   - MOS. TREATMENT REMAINING

26. **IS TREATMENT FOR ORTHODONTICS?**

27. **DATE OF PRIOR PLACEMENT**

28. **EXAMINATION AND TREATMENT PLAN – LIST IN ORDER**

<table>
<thead>
<tr>
<th>TOOTH</th>
<th>SURFACE</th>
<th>DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)</th>
<th>DATE OF SERVICE</th>
<th>ADA CODE</th>
<th>FEE</th>
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29. **REMARKS FOR UNUSUAL SERVICES**

30. **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.**

TOTAL FEE

31. **ADDRESS WHERE TREATMENT WAS PERFORMED (CITY, STATE, ZIP)**

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See reverse side for instructions

An Independent Licensee of the Blue Cross and Blue Shield Association

Form No. 15-011 (07-06)
HOW TO COMPLETE A CLAIM

If you need assistance completing this form please call Blue Cross of Idaho Dental Customer Service at 1-800-289-7929 between 8:00 a.m. and 6:00 p.m. MT, Monday through Friday.

COMPLETED BY SUBSCRIBER (Please print clearly):
1. PATIENT NAME (First, Middle Initial, and Last) – Fill in name of the person treated
2. RELATIONSHIP TO ENROLLEE – Check one of the following:
   (1) Self  (2) Spouse  (3) Child  (4) Other
3. GENDER – Check off the gender of the patient
4. PATIENT BIRTH DATE – Enter month / day / year. If left blank, payment may be delayed
5. EMPLOYEE/ENROLLEE (First, Middle Initial, and Last) – Fill in name of enrollee
6. ENROLLEE I.D. NO. – Enter nine digit identification number assigned by Blue Cross of Idaho
7. ENROLLEE BIRTH DATE – Enter month / day / year
8. EMPLOYEE MAILING ADDRESS – Fill in Street address
9. EMPLOYER (Company) – Fill in your employer name
10. GROUP # – Fill in your employer group number.
11. CITY, STATE, ZIP – Enrollee’s City, State, and Zip
12. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? – If yes, indicate: Dental plan name, group number, name and address of carrier

COMPLETED BY DENTIST (Please print clearly):
13. DENTIST NAME – Fill in the name of treating dentist
14. MAILING ADDRESS – Enter mailing address of dentist office
15. CITY, STATE, ZIP – Dentist’s City, State, and Zip
16. DENTIST SSN OR TIN
17. DENTIST LICENSE # –
18. DENTIST PHONE # – Please include area code
19. FIRST VISIT DATE CURRENT SERIES
20. PLACE OF TREATMENT – Please check one of the following:
   (1) Office  (2) Hospital  (3) Other
21. RADIOGRAPHS OR MODELS ENCLOSED – Check Yes or No
22. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY – Check Yes or No
23. IS TREATMENT RESULT OF AUTO ACCIDENT – Check Yes or No
24. OTHER ACCIDENT – Check Yes or No
25. IF PROSTHESIS IS THIS INITIAL PLACEMENT – Check Yes or No
26. IS TREATMENT FOR ORTHODONTICS – Check Yes or No
27. DATE OF PRIOR PLACEMENT – Fill in date of prior placement
28. EXAMINATION AND TREATMENT PLAN – List tooth numbers, tooth surfaces, service description, date of service, procedure code(s) and fee(s)
29. REMARKS FOR UNUSUAL SERVICES – Enter any remarks pertaining to these services
30. TREATING DENTIST SIGNATURE AND DATE
31. ADDRESS WHERE TREATMENT WAS PERFORMED (City, State, Zip)