



Dental Claim Form

Statement of Actual Services Pretreatment Estimate

PATIENT INFORMATION	1. PATIENT NAME		2. RELATIONSHIP TO ENROLLEE <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		3. GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female		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. EMPLOYER (COMPANY)		10. GROUP #							
	11. CITY, STATE, ZIP													
	12. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>if yes, indicate</i>		DENTAL PLAN NAME		GROUP NO.		NAME AND ADDRESS OF CARRIER							
	AUTHORIZATION TO RELEASE INFORMATION – I hereby authorize any provider, insurer or other organization to release any information regarding the dental history, treatment, or benefits payable for this claim to Blue Cross of Idaho or its authorized agent for the purpose of determining benefits payable. This authorization or a copy shall be valid for one year from the date of signature.				SIGNED (PATIENT OR PARENT IF MINOR)		DATE							
	AUTHORIZATION TO PAY BENEFITS TO DENTIST – I hereby authorize payment directly to the below named dentist of the dental benefits otherwise payable to me.				SIGNED (EMPLOYEE)		DATE							
	I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.				I HEREBY AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THE BELOW NAMED DENTAL ENTITY.									
	SIGNED (PATIENT, OR PARENT IF MINOR)				DATE		SIGNED (INSURED PERSON)		DATE					
	BILLING DENTIST	13. DENTIST NAME			22. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		NO		YES		IF YES, ENTER BRIEF DESCRIPTION AND DATES			
		14. MAILING ADDRESS			23. IS TREATMENT RESULT OF AUTO ACCIDENT?									
		15. CITY, STATE, ZIP			24. OTHER ACCIDENT?									
16. DENTIST SSN OR TIN		17. DENTIST LICENSE #		18. DENTIST PHONE #		25. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?		(IF NO, REASON FOR REPLACEMENT)		27. DATE OF PRIOR PLACEMENT				
19. FIRST VISIT DATE CURRENT SERIES		20. PLACE OF TREATMENT <input type="checkbox"/> Office <input type="checkbox"/> Hospital <input type="checkbox"/> Other		21. RADIOGRAPHS OR MODELS ENCLOSED? <input type="checkbox"/> Yes <input type="checkbox"/> No		26. IS TREATMENT FOR ORTHODONTICS?		IF SERVICES ALREADY COMMENCED, ENTER		DATE APPLIANCES PLACED		MOS. TREATMENT REMAINING		
TO BE COMPLETED BY ATTENDING DENTIST		Indicate missing teeth with an 'X' 			28. EXAMINATION AND TREATMENT PLAN – LIST IN ORDER									
	TOOTH				SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)			DATE OF SERVICE mm dd yy		ADA CODE	FEE		
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.														
SIGNED (TREATING DENTIST)				LICENSE NUMBER				DATE						
31. ADDRESS WHERE TREATMENT WAS PERFORMED (CITY, STATE, ZIP)														
										TOTAL FEE				

See reverse side for instructions

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)