DENTAL CLAIM FORM

BC & BS Use Only
Claim Number:

Attending Dentist's Statement

☐ **Statement of Actual Services.** ☐ **Pretreatment Estimate.** **(Check One)**

1. Patient's Name:
2. Sex: Male Female
3. Patient's Birthdate:
4. Relationship to Employee: Self Spouse Child Student Handicapped
5. If Full-Time Student, School and City:
6. Employee (Subscriber) Name: First Initial Last
7. Subscriber ID Number:
8. Employee (Subscriber) Mailing Address:
City State Zip Code
9. Employer (Company) Name:
10. Is Parent Covered by Another Dental Plan?: ☐ No ☐ Yes Dental Plan Name: Union Local: Group No.: Name a nd Address of Carrier:

I have reviewed the following treatment plan. I authorize the release of any information relating to this claim.

Signed (Patient or parent if a minor): Date:

*** To be completed by Dentist, or attach an itemized superbill.**

11. Dentist's Name Mailing Address City State Zip Code
12. Dentist's Social Security No.:
13. Provider Number:
14. Dentist's Phone Number:
15. First Visit Date - Current Series:
16. Place of Treatment: ☐ Office ☐ Hosp. ☐ ECF ☐ Other
17. Radiographs or Models Encl.?: ☐ No ☐ Yes, How Many? ______
18. Is treatment result of occupational illness or injury?: ☐ No ☐ Yes If yes, enter brief descr. and dates: ______
19. Is treatment result of auto accident?: ☐ No ☐ Yes If yes, enter brief descr. and dates: ______
20. Other accident?: ☐ No ☐ Yes If yes, enter brief descr. and dates: ______
21. Are any services covered by another plan:? ☐ No ☐ Yes If yes, enter brief descr. and dates: ______
22. If prosthesis, is this the initial placement?: ☐ No ☐ Yes If no, reason for replacement: ______
23. Date of Prior Placement:
24. Is treatment for orthodontics?: ☐ No ☐ Yes If services already commenced, enter Date Appliances Placed: ______ Months of Treatment Remaining: ______

TOOTH # OR LETTER	SURFACE (ie: MO DBLIG)	DESCRIPTION OF SERVICE (including X-rays, Prophylaxis, Materials Used, Etc.)	DATE SERVICE PERFORMED MM DD YY	PROCEDURE CODE NUMBER	DENTIST'S FEE	INTERNAL CODE	CREDIT TOWARD DENTIST'S FEE	LOCAT ION	UNIT	LINE ITEM
				0	.00			1	01	1
				0	.00			1	01	2
				0	.00			1	01	3
				0	.00			1	01	4
				0	.00			1	01	5
				0	.00			1	01	6
				0	.00			1	01	7
				0	.00			1	01	8
				0	.00			1	01	9
				Total Fee Actually Charged	.00		Disp. Code 1	Payee Code 1		

Dentist's Statement: I hereby certify the services listed have been or will be provided by me.

Dentist's Signature Date

Claims for crowns, inlays and onlays should include preoperative X-rays.

*** Please Note: Predetermination of benefits does not guarantee payment.**

Pretreatment estimates are calculated based on current available benefits and the patient's eligibility. Estimates are subject to modification based upon remaining benefits available and eligibility that applies at the time services are completed and a claim is submitted for payment.

CHL005 1 031001 0 REV 2

HOW TO FILE A CLAIM

1. Complete Section 1.

2. Ask your dentist to complete Sections 2 and 3, and sign the claim form; or attach an original itemized superbill.

3. All bills must include the following:

   Letterhead Bill
   Patient's Name
   Date(s) of Service
   Charge for Each Service
   Description and Procedure Code of Each Service
   Tooth Number and Surface
   Dentist's Social Security Number or Tax Identification Number

4. Send completed claim form to:

   Blue Cross and Blue Shield of Massachusetts
   P.O. Box 9199
   N. Quincy, MA 02171-9199

NOTE: Claims must be submitted within one year of the date of service. Claims with incomplete information will be returned to the subscriber.

HOW TO REACH US

Call: Please call the phone # on the front of your BCBS ID card.

Telecommunications Device
for the Deaf Service Number: (617) 956-3801

Write: Member Service
Blue Cross and Blue Shield of Massachusetts
P.O. Box 9199
N. Quincy, MA 02171-9199