DENTAL SERVICES CLAIM FORM

BlueCross BlueShield of Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association.

☐ DENTIST'S PRE-TREATMENT ESTIMATE
☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

☐ **Blue Shield – Oral Surgery** ☐ **Dental Insurance**
☐ **Major Medical**

PART I – TO BE COMPLETED BY EMPLOYEE

1. PATIENT NAME First Initial Last
2. Relationship to Employee: Self | Spouse | Child | Other
3. Sex: M | F
4. Patient Birthdate: Mo. | Day | Year
5. If full-time student: School | City
6. Employee/Subscriber Name First Middle Last
7. Employee Social Security No./Contract No.
8. Employee/Subscriber Mailing Address

City State Zip

9. Employer (Company) Name and Address
10. I hereby authorize release of any information relative to this claim to the insurer and direct that benefits be made payable to: ☐ Dentist ☐ Myself

Date Employee or Spouse Signature

11. Do you or your spouse have any other dental insurance? ☐ Yes ☐ No
If yes, please answer the following questions:
Policyholder's Name:
SSN or ID No.:
Name and Address
of Policyholder's Employer:

PART II – TO BE COMPLETED BY ATTENDING DENTIST

Question	No	Yes	
12. Is treatment result of occupational illness or injury?			If YES, enter brief description and dates
13. Is treatment result of auto accident?			
14. Other accident?			
15. Are any services covered by another plan or Medicare B?			
16. If prosthesis, is this initial placement?			(If NO, Reason for Replacement) — 17. Date of Prior Placement
18. Is treatment for orthodontics?			If services already commenced: Enter — Date of case diagnosis

Date Appliances Placed — Mos. Treatment Remaining

19. REMARKS FOR UNUSUAL SERVICES

X-rays submitted ☐ Yes ☐ No

FACIAL — 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 — A B C D E F G H I J — LINGUAL — UPPER — RIGHT — LEFT — LOWER — PRIMARY — PERMANENT — K L M N O P Q R S T — LINGUAL — 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 — FACIAL

Ir. Indicate Missing Teeth With An "X"

20. EXAMINATION AND TREATMENT PLAN. LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32.

A Tooth No. or Letter	B Surface	C Date of Service	D Place of Service *	E Procedure Code	Modifiers	Description of Services (Including X-rays, prophylaxis, materials used, etc.)	F Diagnosis Code	G Charges	H (For Administrative Use Only) Type Service	Days Units	MP SPI	AC Code	Disp	RB LF

21. **Signature of Dentist**
(I certify that the statements on the reverse apply to this bill and are made a part hereof.)

Signed Date

22. Your Patient's Account No.

26. Accept Assignment *(See back)* Yes ☐ ☐ No

27. Your Social Security No.

28. Your Employer I.D. No.

23. Total Charge

24. Amount Paid

25. Balance Due

29. Physician's or Supplier's Name, Address, Zip Code and Telephone No.

I.D. No.

*** PLACE OF SERVICE CODES**

1 – Inpatient Hospital	3 – Doctor's Office	5 – Day Care Facility	7 – Nursing Home	9 – Ambulance	A – Independent Laboratory
2 – Outpatient Hospital	4 – Patient's Home	6 – Night Care Facility	8 – Skilled Nursing Facility	0 – Other Locations	B – Other Medical/Surgical Facilities

CLAIM FORM INSTRUCTIONS

PLEASE BE SURE TO CHECK THE APPROPRIATE BLOCK ON THE FRONT OF THE CLAIM FORM (I.E. BLUE SHIELD – ORAL SURGERY, DENTAL INSURANCE, OR MAJOR MEDICAL).

ITEMS 1-11 – MEMBER INFORMATION

The patient provides information on Items 1-11 in order for the coverage to be identified. (Note: *All* items must be completed before we can process your claim.)

ITEMS 12-29 – DENTIST INFORMATION

Please complete Items 12-29.

SIGNATURE ITEM 21:
I certify that I personally performed the described services or they were performed by my employee under my immediate personal supervision.

ASSIGNMENT ITEM 26:
When I mark Item 26 “Yes” and properly complete this claim form, I understand that any covered benefit payment will be made directly to me.

When I mark Item 26 “No” or fail to mark it either “Yes” or “No,” I further understand that any covered benefit payment will be made directly to the insured subscriber.

ITEM 27:
Complete this item if filing under a corporation name.

A pre-determination of benefits can be made only when such charges for the course of treatment to be performed will exceed $100.00. For such cases, please complete all items on the claim form except Item No. 20C (date(s) of service) indicating the treatment plan and the estimated charges and mail to the address below. A pre-determination form will be returned to you indicating the allowable amount. This amount is always subject to the deductible and coinsurance provisions of the contract. Upon completion of the services indicated on the treatment plan, enter the date(s) the services were performed and submit the pre-determination form for payment of benefits.

MAIL ALL OTHER DENTAL CLAIM FORMS TO:

Columbia Service Center
Dental Claim Department
P.O. Box 100300
Columbia, South Carolina 29202-3300

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice.

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance online at contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. PC 명조 (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de ce plan médical, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-396-0190 . (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در بارەی این برنامەی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شمارەی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)