



A nonprofit independent licensee of the Blue Cross Blue Shield Association

Customer Submitted Dental Claim Form

Mail Completed Forms to:
P.O. Box 21146, Eagan, MN 55121



Subscriber Information (from ID card)

Subscriber ID	Subscriber Last Name	Subscriber First Name
Subscriber Address		Subscriber City, State, Zip

Patient Information (who received services?)

Patient Name	Patient Date of Birth	Relationship to Subscriber (select one) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other
Patient Address		Patient City, State, Zip
Is another insurance primary?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, please provide carrier name:

About Your Visit

Type of Claim Being Submitted	<input type="checkbox"/> Pretreatment Estimate for Services to be rendered in the future <input type="checkbox"/> Services already performed	
Is treatment due to an accident?	<input type="checkbox"/> No <input type="checkbox"/> Yes (enter accident date)	Accident Date:

Name of Treating Dentist	Treating Dentist NPI	Treating Dentist Tax ID
Treatment Location Address		Treatment Location City, State, Zip
Is the dentist part of a group?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Group Name:

Date of Service	CDT Procedure code or description of service	Tooth # (if applicable)	Tooth Surface (if applicable)	Oral Cavity (if applicable)	Cost

Please attach itemized bill from the provider

Total

Payment and Signature

Have you already paid for this service?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If no, would you like us to pay the provider directly?	<input type="checkbox"/> No, pay me directly <input type="checkbox"/> Yes, I authorize my insurer to make payments directly to the provider on my behalf

I CERTIFY THAT THE INFORMATION SUBMITTED IS ACCURATE TO THE BEST OF MY KNOWLEDGE, I AUTHORIZE THE RELEASE OF ANY RELEVANT INFORMATION TO MY INSURANCE CARRIER.

SUBSCRIBER SIGNATURE:

DATE:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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 each violation.

Mail completed form and any supporting documentation to: P.O. Box 21146, Eagan, MN 55121

INSTRUCTIONS

ITEMIZED BILL(S) FOR SERVICES **MUST BE SUBMITTED** WITH THIS FORM IN ORDER FOR REIMBURSEMENT TO BE CONSIDERED.

Original itemized receipts including all pertinent information **must be submitted** with this claim form.

The itemized bill must clearly indicate all of the following:

- Patients full name and address on the letterhead of the provider of service or supply
- Treating provider Tax identification number and National Provider Identifier (NPI)
- Type of service performed
- Place of service
- Date and charge for each service provided

Complete this form with the following information:

- Identification Number
- Subscriber Last Name
- Subscriber First Name
- Patient's full name
- Patient's date of birth
- Patient's relationship to the Subscriber Holder
- Treating providers name and address
- Treating providers tax identification number and National Provider Identifier (NPI)
- For coordination of benefits (secondary insurance payment)
a copy of the primary insurance explanation of payment **must be included** with this form.
- Tooth Number(s) are required for Fillings, sealants, extractions, crowns and root canals.
- Tooth Surface Letter(s) are required for Fillings
- Sign and date the form