Shaded Area is for Plan Use Only

DENTAL CLAIM FORM

BlueCross® BlueShield®
Federal Employee Program®

PLEASE TYPE OR PRINT

1. Identification Number	2. Group Number or Enrollment Code	3. Patient's Name *(First, Middle Initial, Last)*

4. Patient's Date of Birth Mo. / Day / Year	5. Patient's Sex	6. Patient's Relationship to Subscriber: EE SP CH
	Female☐ Male☐	*Self*☐ *Spouse*☐ *Child*☐ *Other*☐ *Explain:*

7. Subscriber's Name *(First, Middle Initial, Last)*	8. Daytime Telephone Number *(Include Area Code)*

Subscriber's Address *(Street and Apt. or Box Number)* ☐ *CHECK IF NEW ADDRESS*	*City*	*State*	*Zip Code*

Email Address

9. Is the patient covered under other dental insurance? No ☐ Yes ☐

If yes, name of other insurance: _____

Name of Policy Holder _____

Other Policy ID Number _____

OFFICE USE ONLY

POI

SOPL

10. Was patient's condition due to:

Work related accident? No☐ Yes☐

An auto accident? No☐ Yes☐

Other accidental injury? No☐ Yes☐

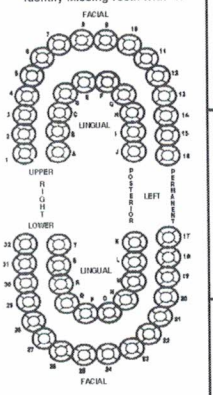
If yes, give the date of accident: Mo. / Day / Year _____

Please attach a statement with details indicating when, where and the manner in which the injury occured.

Was another party at fault? No☐ Yes☐

To be completed by Dentist (See instructions on reverse.)

Identify Missing Teeth With "X"



13. MISSING TEETH:

Identify missing teeth on chart with X. Indicate by tooth number, the date each tooth was lost or extracted, if known:

TOOTH	DATE	TOOTH	DATE

14. ORTHODONTIA:

Is orthodontic treatment included in the services listed below? No☐ Yes☐

If yes, is this initial treatment? No☐ Yes☐

Date appliance was placed: _____

Expected completion date of orthodontic treatment: _____

Total charge for active treatment _____

11. THIS CLAIM FORM MUST BE SIGNED. IF NOT, IT WILL BE RETURNED. I certify that the above information is correct and apply for benefits under my dental coverage. I authorize any dentist or physician in possession of information concerning the patient to furnish such information upon request.

Signature of Subscriber or Spouse _____ *Date* _____

12. ASSIGNMENT OF BENEFITS: (Please see the reverse side of this form for further information.)

No☐ Yes☐

If "yes" block above is marked, I authorize the Blue Cross and Blue Shield Plan to pay benefits directly to the provider of the services listed below.

Signature of Subscriber or Spouse _____ *Date* _____

The Plan may, at its discretion, accept or deny an assignment of benefits.

15. CROWNS, BRIDGES AND DENTURES:

Do services include the replacement of a prosthesis (crown, bridge, denture)? No☐ Yes☐

If yes, what was the orginal prosthesis? _____

Indicate date of original placement or restoration and orignal teeth involved: Mo. / Day / Year _____

Tooth Number(s) _____

Reason for replacement: Original Damaged☐ Lost or stolen☐ Other: *(explain)* _____

See item 20 on the back of this form for x-ray requirements.

RPL ☐

SPI ☐

16. Do charges include a consultation? No☐ Yes☐ If yes, name of referring provider _____

A report from the consulting specialist is required. See item 16 on the back of this form for additional information required for a consultation.

17. **Description of Services** (See instructions on reverse.)

OFFICE USE ONLY

Date of Service M D Y	A.D.A. Procedure Code	Detailed Description of Services	Tooth No. or Letter	Surfaces	No. of Times Perf.	Place OFF	Place IN	Place OP	Charge	Other Ins. Cons.	Other Ins. Paid	ADI	Remarks, Notes

19. TOTAL CHARGE

P = RC =

20. Are x-rays enclosed? No☐ Yes☐ (See item 20 on the back of this form.)

18. Please check the appropriate box.

☐ ESTIMATE OF ELIGIBLE BENEFITS

The treatment listed is necessary in my professional judgement and I request Estimate of Eligible Benefits. **Note: Dentist's Tax ID Number or Social Security Number is required.**

■ WORK COMPLETED - PAYMENT REQUESTED

I certify that the services have been performed by me or under my personal supervision and are necessary in my professional judgement. Charges shown are my usual charges.

Dentist's Signature _____ *Phone #* _____

21. Scott H. Leaf, D.D.S. 27-0773127

Dentist's Name

9316-C Old Keene Mill Road

Address

Burke ✚ Virginia 22015

City *State* *Zip Code*

■ Tax ID No. or ☐ SSN

Reviewed By: _____ PAY ☐

CUT0131-1S 12/13