Dental Claim Form

This form is not intended for electronic claim submissions.

Dental Services
P.O. Box 9201
Oxnard, CA 93031-9201

EMPLOYEE PART A

1. PATIENT NAME	2. RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD OTHER	3. SEX MALE FEMALE	4. PATIENTS BIRTHDATE MONTH DAY YEAR	5. IF FULL TIME STUDENT SCHOOL CITY

6. EMPLOYEE NAME FIRST MIDDLE LAST	7. EMPLOYEE/SUBSCRIBER CONTRACT NUMBER	8. EMPLOYEE/SUBSCRIBER BIRTHDATE MONTH DAY YEAR

EMPLOYEE MAILING ADDRESS CITY, STATE, ZIP	9. EMPLOYER (COMPANY) NAME AND ADDRESS
10. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ☐ YES ☐ NO EMPLOYER (COMPANY NAME) GROUP NO.	11. NAME AND ADDRESS OF OTHER CARRIER(S)

12. EMPLOYEE/SUBSCRIBER NAME (UNDER OTHER CARRIER)	EMPLOYEE/SUBSCRIBER CONTRACT NUMBER	BIRTHDATE MO./DAY/YR	RELATIONSHIP TO PATIENT ☐ SELF ☐ PARENT ☐ SPOUSE ☐ OTHER_____

13. I have been informed of the treatment plan and associated fees. I authorize the release of any information needed to determine benefits for the duration of this claim. ➢ SIGNED (Patient/Guardian) DATE	14. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity. ➢ SIGNED (Employee/Subscriber) DATE

DENTIST PART B

15. NAME OF BILLING DENTIST OR DENTAL ENTITY	23. Is treatment result of occupational illness or injury?	NO	YES	If yes, enter brief description and dates
16. MAILING ADDRESS	24. Is treatment result of auto accident or other accident?			
CITY, STATE, ZIP	25. Are any services covered by another dental plan?			
17. DENTIST SSN OR T.I.N. 18. DENTIST LIC # 19. PHONE #	26. If prosthesis, is this initial placement?			(If no, reason for replacement) 27. Date of prior placement

20. First visit date of current series:	21. Place of treatments Office Hosp ECF Other	22. Radiographs enclosed? Yes, How many? ____ No	28. Is treatment for orthodontics?			If service already commenced: Date appliances placed? Months treatment remaining?

29. EXAMINATION AND TREATMENT PLAN

PRE-TREATMENT ESTIMATE OR STATEMENT OF ACTUAL SERVICE

TOOTH # or LETTER	SURFACE	DESCRIPTION OF SERVICE	DATE SERVICE PERFORMED			PROCEDURE #	FEE		FOR ADMINISTRATIVE USE ONLY

IDENTIFY ALL MISSING TEETH WITH AN "X"

PERMANENT

1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17

PRIMARY

A B C D E | F G H I J

T S R Q P | O N M L K

REMARKS FOR UNUSUAL SERVICES OR DIAGNOSIS

TOTAL FEE		
OTHER POLICY ALLOWED		
AMOUNT PATIENT PAID		
AMOUNT PATIENT PAID		
BALANCE DUE		

30. I hereby certify that the procedures as indicated by date have been completed or are in progress and that the fees submitted are the fees I usually charge and accept for such procedures.

DENTIST SIGNATURE DATE

An Independent Licensee of the Blue Cross Blue Shield Association