Pennsylvania BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 890400
Camp Hill, PA 17089-0400

DENTAL CLAIM FORM

FOR BLUE SHIELD USE ONLY

1. PATIENT'S NAME *(First, Middle, Last)*
2. DATE OF BIRTH Mo. ____ Day ____ Yr. ____
3. SEX (1) M ❑ (2) F ❑
4. GROUP NUMBER
5. INSURED'S I.D. (including alpha prefix)

6. APPLICANT-SUBSCRIBER'S NAME *(First, Middle, Last)*
ADDRESS *(Street, City, State, ZIP Code)*

TELEPHONE NUMBER (AREA CODE) ( ) ________________________

7. RELATIONSHIP OF PATIENT TO APPLICANT-SUBSCRIBER
(1) Self ❑ (2) Spouse ❑ (3) Dependent ❑

8. WAS INJURY OR CONDITION RELATED TO:
(1) Patient's Employment ❑ (3) Auto Accident ❑
(2) Neither Employment nor Auto ❑ (4) Both Employment and Auto ❑

9. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? (1) Yes ❑ (2) No ❑
If YES Plan Name ________________________ Policy Number ________________________

10A. DIAGNOSIS
10B. DATE OF INJURY (ACCIDENT)

11. ARE ANY OF THE FOLLOWING ENCLOSED? X-RAYS ❑ PHOTOS ❑ MODELS ❑ OTHER ❑

12. COMPLETE EXAMINATION AND TREATMENT RECORD IN FULL
List in sequential order from tooth number 1-32 or tooth A-T… If requesting predetermination – omit date service performed.
If more line items are needed please use an additional claim form and attach – completing items 1 and 5 above and check here. ❑

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

SURFACES
M – Mesial F – Facial
O – Occlusal L – Lingual
D – Distal I – Incisal

12A TOOTH NO. OR LETTER	12B SURFACES	12C PROCEDURE CODE	DESCRIPTION OF SERVICES – Itemize (Describe unusual serevices and attach)	12D DATES OF SERVICES Mo. __ Day __ Yr. __	12E PLACE CODE	12F ITEMIZED CHARGES

PLACE CODES } **(1) IH - Inpatient Hospital** **(2) - Outpatient Hospital** **(3) OF - Office** **(11) OL - Other Location**

13. TOTAL CHARGES

14. FOR HOSPITAL CASES ONLY
NAME OF HOSPITAL & CITY
DATE ADMITTED mo.___ day____ yr.___ DATE DISCHARGED mo.___ day___ yr.___

15. HAS FEE BEEN PAID?
(1) Yes ❑
(2) No ❑

16. DOCTOR'S NAME, ADDRESS AND ZIP CODE & I.D. NO.

17A. If crown, inlay/onlay or prosthesis-is this initial placement?
(1) Yes ❑
(2) No ❑
If No { Date of Prior Placement mo.___ day___ yr.___
Reason For Replacement ___________________

17B. DATE OF IMPRESSION/PRESCRIPTION ________________________

18. IS TREATMENT FOR ORTHODONTIC CARE (1) Yes ❑ (2) No ❑
Date 1st Appliance Inserted _________ Date Last Appliance Removed _________

19. PATIENT'S AUTHORIZATION - I herby accept th above treatment plan and authorize release of any information pertaining to the case. I am aware that the dentist is ( ) is not ( ) a participating octor.

Patient's Signature ________________ Date ________

20. DOCTOR'S REQUEST FOR PREDETERMINATION OR PAYMENT (check appropriate box)
❑ (1) Request for Predetermination - I certify that I am legally qualified to perform the reported services. The fees shown are those usually charged to my private, non-insured patients.
❑ (2) Request for Payment - I herby certify that the procedures as indicated by date have been completed by me personally or under my direct supervision. The fees shown are those usually charged to my private, non-insured patients.

21. Doctor's Signature ____________________________________
22. TELEPHONE NUMBER (including area code) ( ) ________________
23. YOUR PATIENT'S ACCOUNT NO. __________________________

Blue Shield Use Only

	BASIC	RIDER A	RIDER B	RIDER C	RIDER D
EFFECTIVE DATE					
TYPE					

AMOUNT OF ADJ.	DATE	CLERK	CONTROL

EXPLANATION:

DENTAL DIRECTOR:

975-1R 10/94

CHECK FOR ITEM 11 READ ❑ RETURNED ❑