Empire BlueCross BlueShield

DENTAL CLAIM FORM

1. CHECK ONE (✓)
❑ DENTIST FEE TREATMENT ESTIMATE
❑ DENTIST STATEMENT OF ACTUAL SERVICES

2. PRIOR AUTHORIZATION NO.
PATIENT ID NO.

3. CARRIER NAME AND ADDRESS
EMPIRE BLUECROSS BLUESHIELD
DENTAL BENEFITS PROGRAMS
P.O. BOX 791
MINNEAPOLIS, MN 55440-0791

PATIENT COVERAGE INFORMATION

4. PATIENT NAME

5. RELATIONSHIP TO EMPLOYEE
❑ SELF ❑ DAUGHTER
❑ SPOUSE ❑ SON
❑ OTHER _____

6. SEX
❑ M ❑ F

7. PATIENT BIRTH DATE
MONTH DAY YEAR

8. IF FULL TIME STUDENT
SCHOOL CITY

9. EMPLOYEE/SUBSCRIBER NAME AND ADDRESS

10. EMPLOYEE/SUBSCRIBER IDENTIFICATION NUMBER

11. EMPLOYEE/SUBSCRIBER BIRTH DATE
MONTH DAY YEAR

12. GROUP NUMBER

13. EMPLOYER NAME AND ADDRESS

14. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ❑ YES ❑ NO - **IF YES, COMPLETE 15-18**
IS PATIENT COVERED BY A MEDICAL PLAN?
❑ YES ❑ NO

15-A. NAME AND ADDRESS OF OTHER CARRIER(S)

15-B. GROUP NUMBER(S)

16. OTHER PLAN-EMPLOYER NAME/ADDRESS

17-A.OTHER PLAN - SUBSCRIBER NAME
(IF DIFFERENT FROM PATIENT(S))

17-B. OTHER PLAN-SUBSCRIBER IDENTIFICATION NUMBER

17-C. SUBSCRIBER BIRTH DATE
MONTH DAY YEAR

18. RELATIONSHIP TO PATIENT
❑ SELF ❑ DAUGHTER
❑ SPOUSE ❑ SON
❑ OTHER _____

19. I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN AND FEES. I AGREE TO BE RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT. I AUTHORIZE RELEASE OF ANY INFORMATION RELATED TO THIS CLAIM.

PATIENT SIGNATURE _____ DATE _____

20. I HEREBY AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THE BELOW NAMED DENTIST ENTITY.

SIGNATURE (EMPLOYEE/SUBSCRIBER) _____ DATE _____

BILLING DENTIST COMPLETES

21. NAME OF BILLING DENTIST OR DENTAL ENTITY

22. ADDRESS WHERE PAYMENT SHOULD BE REMITTED

23. CITY, STATE, ZIP

24. DENTIST SSN OR TIN

25. DENTIST LICENSE NO.

26. PHONE NUMBER

27. 1ST VISIT

28. PLACE OF TX
OFF ❑ HOSPITAL ❑
ECF ❑ OTHER ❑

29. RADIOGRAPHS OR MODELS ENCLOSED? NO ❑ YES ❑ HOW MANY?

30. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? NO ❑ YES ❑ IF YES, ENTER DESCRIPTION AND DATE

31. IS TREATMENT RESULT OF AUTO ACCIDENT? NO ❑ YES ❑

32. OTHER ACCIDENT? NO ❑ YES ❑

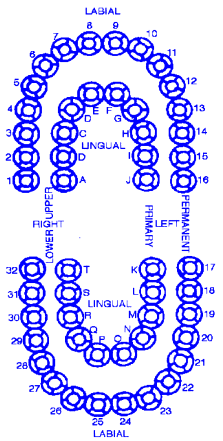
33. IF PROSTHESIS, IS IT INITIAL PLACEMENT? NO ❑ YES ❑ IF NO, REASON FOR REPLACEMENT

34. DATE OF PRIOR PLACEMENT

35. IS TREATMENT FOR ORTHODONTICS? NO ❑ YES ❑ DATE APPLIANCES PLACED?

MISC. TREATMENT REMAINING?

36. IDENTIFY MISSING TEETH WITH "X"



37. EXAMINATION AND TREATMENT PLAN

FOR ADMINISTRATIVE USE ONLY

TOOTH	SURF	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, ETC.)	DATE OF SERVICE MO	DAY	YEAR	PROCEDURE NUMBER	FEE	

38. REMARKS FOR UNUSUAL SERVICES

39. I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THAT THE FEES SUBMITTED ARE THE ACTUAL FEES I HAVE CHARGED AND INTEND TO COLLECT FOR THOSE PROCEDURES.

SIGNED (TREATING DENTIST) _____ LICENSE NUMBER _____ DATE _____

40. ADDRESS WHERE TREATMENT WAS PERFORMED

CITY _____ STATE _____ ZIP CODE _____

41. TOTAL FEE CHARGED	
42. PAYMENT BY OTHER PLAN	
MAX ALLOWABLE	
DEDUCTIBLE	
CARRIER %	
PATIENT PAYS	

Empire BlueCross BlueShield

PATIENT AND INSURED INSTRUCTION

We need all the information requested on the front of this form to process your claim. Please help us to serve you by filling in all the boxes asking for information about the patient and the subscriber on the upper part of the claim which includes items 1 through 20. Please print or type. **THIS NEW CLAIM FORM SUPPORTS IMAGING TECHNOLOGY WHICH WILL IMPROVE SERVICE TO OUR VALUED CUSTOMER.**

IMPORTANT - COPY YOUR IDENTIFICATION NUMBER EXACTLY AS IT APPEARS ON YOUR IDENTIFICATION CARD.

After filling in the upper part of the claim form, please give this form to your dentist who can fill in the lower part of the form which includes items 21 through 42.

PATIENT'S SIGNATURE

The patient must sign the claim form, authorizing the release of information as described below. If the patient is a minor, the signature must be that of the patient's parent or legal guardian.

"I hereby authorize any dentist, physician, health care practitioner, hospital, clinic or other medical or dental related facility to furnish any and all records pertaining to dental or medical history, services rendered, or treatment given to me or my dependent for purposes of review, investigation or evaluation of this claim.

I also authorize Empire BlueCross BlueShield, or its agents, to disclose to a hospital or health care service plan, self-insurer or an insurer, any such dental or medical history information obtained if such disclosure is necessary to allow the processing of any claim.

If my coverage is under a group contract held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of this claim or terms of coverage of my insurance policy, including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon me, my heirs, executors or administrators."

INSTRUCTIONS FOR ORTHODONTIC SERVICES

To facilitate processing of pretreatment estimates for Orthodontic services, the claim form should identify:

- Dates of service and fees for each procedure
- Monthly active treatment fee, date active treatment started, total number of months required
- Total fee charged
- Type of dentition, type of malocclusion, description of malocclusion
- Whether treatment is full or limited, type of appliance, treatment description

INSURANCE FRAUD STATEMENT

PURSUANT TO REGULATION 95 OF THE NEW YORK STATE INSURANCE DEPARTMENT, "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, 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 THE CLAIM FOR EACH SUCH VIOLATION."