

ATTENDING DENTIST'S STATEMENT

	IECK ONE: USE ONE FORM	MAIL TO: BLUE CROSS AND BLUE SHIELD OF ILLINOIS POST OFFICE BOX 23059														
	FRE-INEATMENT ESTIMA	BELLEVILLE, ILLINOIS 62223-0059														
	1. PATIENT NAME 2. RELAT FIRST M.I. LAST □ SE □ SP □ SP						F 🗆 CHILD		□ M MO. / DAY / YEAR SCHOOL CITY							
ATION	6. EMPLOYEE/SUBSCRIBER NAME AND MAILING ADDRESS						,	7. EMPLOYEE/SUBSCRIBER IDENTIFICATION NUMBER 8. EMP/SUB BIRTH DATE MO. / DAY / YEAR								
PATIENT INFORMATION	9. EMPLOYER (COMPANY) NAME AND ADDRESS						10. GROUP NO.	11. IS PATIENT COVERED BY ANOTHER PLAN? IF YES, COMPLETE BOXES 12A THRU 15. DENTAL: YES NO MEDICAL: YES NO								
ENT II	12-A. NAME AND ADDRESS		12-B. GROUP NUMBER(S)													
PAT	13. NAME AND ADDRESS OF EMPLOYER						14-A. OTHER EMPLOYEE/SUBSCRIBER NAME (IF DIFFERENT THAN PATIENT'S)						"S)			
	14-B. EMPLOYEE/SUBSCRIBER IDENTIFICATION NUMBER 14-C				. EMPLOYEE/SI MO. / DAY / Y	UBSCRIBER BIRTH D <i>I</i> EAR	TE 15. RELATIONSHIP TO PATIENT SELF CHILD [HILD 🗆 :	SPOUSE [OTHER	
I UNDERSTAND THAT BLUE CROSS AND BLUE SHIELD'S USE OR DISCLOSURE OF INFORMATION, WHETHER FURNISHED BY ME OR OBTAINED FROM OTHER SOURCE BE IN ACCORDANCE WITH THE FEDERAL PRIVACY REGULATIONS UNDER HIPAA (H ACCOUNTABILITY ACT OF 1996). I AUTHORIZE RELEASE OF ANY INFORMATION RETHAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.					I AS MEDICAL PR NSURANCE PORTA	OVIDERS, SHALL ABILITY AND		I HEREBY AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THE BELOW NAMED DENTAL ENTITY.								
SIGN	ED (PATIENT, OR PARENT IF M	NOR)			DATE		SIGNED (INSURED PERSOI	N)					D	ATE		
	16. DENTIST NAME						24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? NO YES				IF YE	F YES, ENTER BRIEF DESCRIPTION AND DATES				
NOIL	17. MAILING ADDRESS				25. IS TREATMENT RESUL ACCIDENT?											
ORMA	CITY STATE ZIP						26. OTHER ACCIDENT?									
DENTIST INFORMATION	18. DENTIST SOC. SEC. NO. OR TIN 19. DENTIST L			CENSE NO. 20. DENTIST PHONE			27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?									
DENTI	21. FIRST VISIT DATE CURRENT SERIES 22. PLACE OF TREATMENT OFFICE/HOSP/ECF/OTHER			23. RADIOGRAPHS OR MODELS ENCLOSED? ☐ YES ☐ NO			INITIAL DI ACEMENTO				1 '	F NO, REASON FOR REPLACEMENT) ATE OF PRIOR PLACEMENT				
					HOW MA	NY?	29. IS TREATMENT FOR ORTHODONTICS?					YES, DATE MOS. TREATMENT PLIANCE PLACED: REMAINING:				
	IDENTIFY MISSING	TEETH WITH ")	X"				ATMENT PLAN - LIST IN ORD	ER FROM TO	OTH NO.	1 THRO	OUGH T		E CHARTING			
	FACIA	AL	Χ"	TOOTH # OR LETTER	SURFACES	D	ATMENT PLAN - LIST IN ORD DESCRIPTION OF SERVICE /S, PROPHYLAXIS, MATERIAL		DA		RVICES	1	FEE FEE	FOR ADM	IINISTRATIVE E ONLY	
	FACI	AL 9 (10)			SURFACES	D	DESCRIPTION OF SERVICE		DA	TE SER	RVICES	PROCEDURE		FOR ADM		
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	FACIO	AL 9 (10)	2) (13) (14) (15)		SURFACES	D	DESCRIPTION OF SERVICE		DA	TE SER	RVICES	PROCEDURE		FOR ADM		
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PLEASE REVIEW BEFORE SUBMITTING CLAIM

INFORMATION FOR PATIENT

- 1. Complete items one (1) through fifteen (15) in full to assist with positive identification and prompt payment. Please print or type. Your group and Subscriber Identification number can be found on your Blue Cross and Blue Shield ID card.
- 2. You must sign the claim form under the Patient Information section indicating that the information is correct and authorizing payment.
- 3. The patient (or parent, if the patient is a minor) must sign the "Authorization to Release Information".
- 4. If total charges for the planned course of treatment can reasonably be expected to be \$300 or more, it is recommended that a pre-treatment estimate be submitted prior to the commencement of the course of treatment. Blue Cross will notify you and your dentist of benefits payable.

Estimated benefits are subject to your coverage being in force at time services are performed and are subject to the specific limitations and exclusions listed in your benefit plan.

Please refer to your Certificate of Coverage for a description of covered services, percentage of fees payable, limitations and exclusions.

The completed form should be mailed to the address shown below.

NOTE: Any person who knowingly presents false, incomplete or misleading information is guilty of a crime and is subject to a fine or imprisonment or both.

INFORMATION FOR ATTENDING DENTIST

- 1. Complete items 16 through 28 and item 29 on the claim form.
- 2. If total charges for the planned course of treatment can reasonably be expected to be \$300 or more, it is recommended that a pre-treatment estimate be submitted prior to the commencement of the course of treatment. Blue Cross will notify you and your patient of benefits payable.

You and your patient are free to pursue any treatment plan mutually agreed upon. Pre-estimation of benefits is only intended to avoid any misunderstanding among the patient, the dentist, and Blue Cross and Blue Shield, concerning the benefits allowed under terms of the coverage.

- Generally, radiographs will not be required when submitting a claim. However, pre-operative radiographs may be requested in certain situations for dental consultant use in benefit determination.
- 4. If the subscriber has so authorized, benefit payment will be made directly to you.

NOTE: Any person who knowingly presents false, incomplete or misleading information is guilty of a crime and is subject to a fine or imprisonment or both.

Mail Completed Form to: Blue Cross and Blue Shield of Illinois

Post Office Box 23059 Belleville, Illinois 62223-0059