

**Provider Submitted  
Dental Claim Form**



165 Court Street  
Rochester NY 14647

A nonprofit independent  
licensee of the BlueCross  
BlueShield Association

Mail Completed Forms To:

Excellus BlueCross BlueShield  
PO Box 22999  
Rochester, NY 14692

**HEADER INFORMATION**

1. Type of Transaction (Mark all applicable boxes)  
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization  
☐ EPSDT/Title XIX
2. Predetermination/Preauthorization Number

**INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION**

3. Company/Plan Name, Address, City, State, Zip Code

**OTHER COVERAGE**

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY) 7. Gender ☐ M ☐ F 8. Policyholder/Subscriber ID
9. Plan/Group Number 10. Patient's Relationship to Person Named in #5  
☐ Self ☐ Spouse ☐ Dependent ☐ Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

**POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)**

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
13. Date of Birth (MM/DD/CCYY) 14. Gender ☐ M ☐ F 15. Policyholder/Subscriber ID
16. Plan/Group Number 17. Employer Name

**PATIENT INFORMATION**

18. Relationship to Policyholder/Subscriber in #12 Above  
☐ Self ☐ Spouse ☐ Dependent Child ☐ Other
19. Student Status  
☐ FTS ☐ PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY) 22. Gender ☐ M ☐ F 23. Patient ID/Account # (Assigned by Dentist)

**RECORD OF SERVICES PROVIDED**

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

**MISSING TEETH INFORMATION**

34. (Place an 'X' on each missing tooth)	<div>Permanent</div> <div><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 14 <input type="checkbox"/> 15 <input type="checkbox"/> 16</div>																<div>Primary</div> <div><input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G <input type="checkbox"/> H <input type="checkbox"/> I <input type="checkbox"/> J</div>										32. Other Fee(s)				
	<div>32</div> <div><input type="checkbox"/> 32 <input type="checkbox"/> 31 <input type="checkbox"/> 30 <input type="checkbox"/> 29 <input type="checkbox"/> 28 <input type="checkbox"/> 27 <input type="checkbox"/> 26 <input type="checkbox"/> 25 <input type="checkbox"/> 24 <input type="checkbox"/> 23 <input type="checkbox"/> 22 <input type="checkbox"/> 21 <input type="checkbox"/> 20 <input type="checkbox"/> 19 <input type="checkbox"/> 18 <input type="checkbox"/> 17</div>																<div>T S R Q P O N M L K</div>										33. Total Fee				
35. Remarks																															

**AUTHORIZATIONS**

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X  
Patient/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X  
Patient/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

**BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI 50. License Number 51. SSN or TIN

52. Phone Number ( ) - 52A. Additional Provider ID

**ANCILLARY CLAIM/TREATMENT INFORMATION**

38. Place of Treatment  
☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other
39. Number of Enclosures (00 to 99)  
Radiograph(s) ☐ Oral Image(s) ☐ Model(s) ☐
40. Is treatment for Orthodontics?  
☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining 43. Replacement of Prosthesis?  
☐ No ☐ Yes (Complete 44)
44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from  
☐ Occupational illness/injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State

**TREATING DENTIST AND TREATMENT LOCATION INFORMATION**

53. I hereby certify that the procedures as indicated by date have been completed.  
X Signed (Treating Dentist) \_\_\_\_\_ Date \_\_\_\_\_
54. NPI 55. License Number
56. Address, City, State, Zip Code 56A. Provider Specialty Code
57. Phone Number ( ) - 58. Additional Provider ID

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals information concerning any fact material thereto, for the purpose of misleading, 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 violation.

I certify that the procedures as indicated by date, have been completed, personally supervised or rendered by me the attending dentist, that the fees submitted are actual fees I have charged and intended to collect.  
Dentist signature: \_\_\_\_\_ Date: \_\_\_\_\_

For assistance in filing your claim, please read the instructions on the back.

## GENERAL INSTRUCTIONS

- A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #10 window envelope.
- B. In the upper-right of the form, a blank space is provided for the convenience of the payer or insurance company, to allow the assignment of a claim or control number.
- C. All Items in the form must be completed unless it is noted on the form or in the following instructions that completion is not required.
- D. When a name and address field is required, the full name of an individual or a full business name, address and zip code must be entered.
- E. All dates must include the four-digit year.
- F. If the number of procedures reported exceeds the number of lines available on one claim form, the remaining procedures must be listed on a separate, fully completed claim form.

## COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the form in its entirety and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer.

## NATIONAL PROVIDER IDENTIFIER (NPI)

49 and 54 **NPI (National Provider Identifier):** This is an identifier assigned by the Federal government to all providers considered to be HIPAA covered entities. An NPI is unique to an individual dentist (**Type 1 NPI**) or dental entity (**Type 2 NPI**), and has no intrinsic meaning. Additional information on NPI and enumeration can be obtained from the ADA's Internet Web Site: [www.ada.org/goto/npi](http://www.ada.org/goto/npi)

## ADDITIONAL PROVIDER IDENTIFIER

52A and 58 **Additional Provider ID:** This is an identifier assigned to the billing dentist or dental entity other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider's NPI. The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be unique as they are assigned by different entities (e.g., third-party payer; Federal government). Some Legacy IDs have an intrinsic meaning.

## PROVIDER SPECIALTY CODES

56A **Provider Specialty Code:** Enter the code that indicates the type of dental professional who delivered the treatment. Available codes describing treating dentists are listed below. The general code listed as 'Dentist' may be used instead of any other dental practitioner code.

Category / Description Code	Code
<b>Dentist</b> A dentist is a person qualified by a doctorate in dental surgery (D.D.S) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
<b>General Practice</b>	1223G0001X
<b>Dental Specialty</b> (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Dental provider taxonomy codes listed above are a subset of the full code set that is posted at:  
[www.wpc-edi.com/codes/taxonomy](http://www.wpc-edi.com/codes/taxonomy)