Dental Claim Form

Mail to:
Anthem Blue Cross and Blue Shield
P.O. Box 37180
Louisville, KY 40233-7180

Anthem

PART I CUSTOMER AND PATIENT INFORMATION *(please print or type)*

Read instructions on reverse side

1. Customer's name: first / middle / last
2. Home phone number ( )
3. Customer identification number (Shown on your ID card)
4. Customer's address: number / street
5. Business phone ( )
6. Customer's Social Security number — —
7. City / State / ZIP
8. Customer's birthdate / / / Spouse's birthdate / /
9. Group Name
10. Patient's name: first / middle / last
11. Patient's birthdate
12. Age
13. Relation to customer ☐ spouse ☐ child ☐ self ☐ other — Patient's Sex ☐ M ☐ F

14. Do you or your spouse have other dental insurance? ☐ Yes ☐ No

If yes, is the patient covered under that dental insurance? ☐ Yes ☐ No

Policyholder's name ______

Policyholder's employer ______

Other insurance co. ______

Contract/Soc. Sec. number ______

If these services are due to an accident, do you have major medical insurance? ☐ Yes ☐ No

15. I authorize release to Anthem of any information pertaining to this claim.

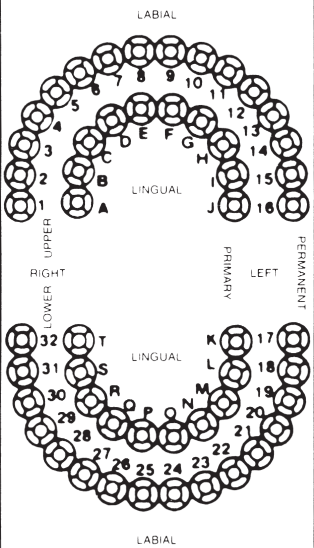
______ Customer or spouse signature ______ Date

By signing the line below, I authorize Anthem, at its option, to issue payment to the provider described on this claim.

______ Customer or spouse signature ______ Date

PART II DENTIST OR PROVIDER INFORMATION *(to be completed by dentist or provider only)*

16.



17. Examination and treatment record — List in order from tooth no. 1 through tooth no. 32

a. Tooth no. or letter	b. Surfaces	c. Description of service (Including X-rays, prophylaxis, materials used, etc.)	d. Date service completed mo./day/yr.	e. Fee for each service performed	f. Procedure code no.
			TOTAL		

Reserved for processing use

18. Please indicate if service was provided:
a. For orthodontic purposes? ☐
b. In patient's home or hospital? ☐
c. As a result of occupational injury? ☐
d. As a result of accident? ☐
date of accident ______

19. If a prosthesis, is this initial placement? Yes ☐ No ☐ If "No" please indicate
Reason for replacement: Date of prior replacement:

20. Are X-rays enclosed? (Not necessary if total dental fee is less than $200)
☐ Yes Indicate number: ______ ☐ No

21. Dentist's name: first / middle / last

Address

City / State / ZIP

22. Office phone number ( )

23. IRS or Social Security number

24. Practice specialty

25. Stamp

26. Additional remarks — unusual services or circumstances (Additional space on back of this page)

27. I certify that the procedures as indicated by date have been completed and that the fees submitted are the fees I usually charge and accept for such procedures.

______ Date ______ Dentist signature

INFORMATION FOR THE CUSTOMER/PATIENT

1. Use this form for all of your claims for dental procedures. Use a separate form for each patient and each dentist who provided services. Please print or type.
2. ***Complete all items in Part I*** of the form, for both the patient and the customer.
3. Sign the form in block 15.
4. Any items of information not completed in Part I will cause a delay in processing your claim.
5. After you have completed Part I, give the form to your dentist.

INFORMATION FOR THE DENTIST

1. Use a separate claim form for each patient and each provider rendering services.
2. Review Part I to make sure the customer has provided all information, especially a signature in block 15. Missing information will cause a delay in processing and payment.
3. Complete Part II with all information pertinent to the patient's treatment. Be sure to mark tooth numbers and surfaces, as well as procedure codes, along with other treatment information.
4. Be sure to include your IRS or Social Security number in block 23.
5. To expedite claims processing, our consultants recommend X-rays if treatment is expected to exceed $200. Staple the X-rays to the top of the form, noting the patient's name and customer's Social Security number, as well as your name and address and the date the X-rays were taken. X-rays will be returned as soon as possible. Please note in Block 20 that X-rays are included.
6. Mail the completed, signed form to the address on the front of this claim form.

Predetermination of Benefits

When charges for a course of treatment are expected to exceed $200, detail your treatment plan on a claim form (including an estimate of charges), and send it to the address on the front. We will return a Benefit Confirmation Form outlining the payments due you; your patient will receive a letter with the same information. This gives you advance information about both our payment and your patient's share of the cost. When you complete the services indicated on the treatment plan, enter the dates the services were performed on the Benefit Confirmation Form and return that form to us for processing and payment.

Additional remarks - unusual services
or circumstances (continued from front)

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INSURANCE FRAUD WARNING
Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.