

- DENTIST'S PRE-TREATMENT ESTIMATE
 DENTIST'S STATEMENT OF ACTUAL SERVICES

- Blue Shield – Oral Surgery** **Dental Insurance**
 Major Medical

PART I – TO BE COMPLETED BY EMPLOYEE				3. Sex M F	4. Patient Birthdate Mo. Day Year	5. If full-time student: School	City
1. PATIENT NAME First Initial Last	2. Relationship to Employee Self Spouse Child Other						
6. Employee/Subscriber Name First Middle Last				7. Employee Social Security No./Contract No.			
8. Employee/Subscriber Mailing Address City State Zip				9. Employer (Company) Name and Address			
10. I hereby authorize release of any information relative to this claim to the insurer and direct that benefits be made payable to: <input type="checkbox"/> Dentist <input type="checkbox"/> Myself Date Employee or Spouse Signature				11. Do you or your spouse have any other dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please answer the following questions: Policyholder's Name: SSN or ID No.: Name and Address of Policyholder's Employer:			

PART II – TO BE COMPLETED BY ATTENDING DENTIST			
12. Is treatment result of occupational illness or injury?	No	Yes	If YES, enter brief description and dates
13. Is treatment result of auto accident?			
14. Other accident?			
15. Are any services covered by another plan or Medicare B?			
16. If prosthesis, is this initial placement?		(If NO, Reason for Replacement)	17. Date of Prior Placement
18. Is treatment for orthodontics?		If services already commenced: Enter	Date of case diagnosis
Date Appliances Placed		Mos. Treatment Remaining	
19. REMARKS FOR UNUSUAL SERVICES			
X-rays submitted <input type="checkbox"/> Yes <input type="checkbox"/> No			
I. Indicate Missing Teeth With An "X"			

20. EXAMINATION AND TREATMENT PLAN. LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32.														
A Tooth No. or Letter	B Surface	C Date of Service	D Place of Service*	E		Description of Services (Including X-rays, prophylaxis, materials used, etc.)	F Diagnosis Code	G Charges	H (For Administrative Use Only)					
				Procedure Code	Modifiers				Type Service	Days Units	MP SPI	AC Code	Disp	RB LF

21. Signature of Dentist <i>(I certify that the statements on the reverse apply to this bill and are made a part hereof.)</i>	26. Accept Assignment (<i>See back</i>) Yes <input type="checkbox"/> No <input type="checkbox"/>	23. Total Charge	24. Amount Paid	25. Balance Due
Signed _____ Date _____	27. Your Social Security No.	29. Physician's or Supplier's Name, Address, Zip Code and Telephone No.		
22. Your Patient's Account No.	28. Your Employer I.D. No.	I.D. No.		

*** PLACE OF SERVICE CODES**
 1 – Inpatient Hospital 3 – Doctor's Office 5 – Day Care Facility 7 – Nursing Home 9 – Ambulance A – Independent Laboratory
 2 – Outpatient Hospital 4 – Patient's Home 6 – Night Care Facility 8 – Skilled Nursing Facility 0 – Other Locations B – Other Medical/Surgical Facilities

CLAIM FORM INSTRUCTIONS

PLEASE BE SURE TO CHECK THE APPROPRIATE BLOCK ON THE FRONT OF THE CLAIM FORM (I.E. BLUE SHIELD – ORAL SURGERY, DENTAL INSURANCE, OR MAJOR MEDICAL).

ITEMS 1-11 – MEMBER INFORMATION

The patient provides information on Items 1-11 in order for the coverage to be identified. (Note: *All* items must be completed before we can process your claim.)

ITEMS 12-29 – DENTIST INFORMATION

Please complete Items 12-29.

SIGNATURE ITEM 21:

I certify that I personally performed the described services or they were performed by my employee under my immediate personal supervision.

ASSIGNMENT ITEM 26:

When I mark Item 26 “Yes” and properly complete this claim form, I understand that any covered benefit payment will be made directly to me.

When I mark Item 26 “No” or fail to mark it either “Yes” or “No,” I further understand that any covered benefit payment will be made directly to the insured subscriber.

ITEM 27:

Complete this item if filing under a corporation name.

A pre-determination of benefits can be made only when such charges for the course of treatment to be performed will exceed \$100.00. For such cases, please complete all items on the claim form except Item No. 20C (date(s) of service) indicating the treatment plan and the estimated charges and mail to the address below. A pre-determination form will be returned to you indicating the allowable amount. This amount is always subject to the deductible and coinsurance provisions of the contract. Upon completion of the services indicated on the treatment plan, enter the date(s) the services were performed and submit the pre-determination form for payment of benefits.

MAIL ALL OTHER DENTAL CLAIM FORMS TO:

**Columbia Service Center
Dental Claim Department
P.O. Box 100300
Columbia, South Carolina 29202-3300**