

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION		3001011				ï	Claims Ma	ailing A	Address:							
Type of Transaction (Mark all applicable boxes)								BlueCross Dental P.O. Pay 1126 File Croys Village II 60000 Page 1 of 1								
Statement of Actual Services Request for Predetermination/Preauthorization								P.O. Box 1126, Elk Grove Village, IL 60009 Page 1 of 1 Electronic Payor ID: CBC01								
EPSDT / Title XIX		Member Services: (800) 613-2624/phone (888) 208-8290/fax														
Predetermination/Preauthorizat	╬	POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)														
2. Fredetermination/Freauthonzat	\vdash	12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code														
						┨''	z. Folicyfloidei	/ Subsci	ilbei ivaille ((Last, First, IVIII	uule IIIII	ai, Suilix), A	Juless, Olly, Sta	ate, Zip Code		
INSURANCE COMPANY/DE			ORMATIO	N .		-										
3. Company/Plan Name, Address,	City, State,	Zip Code														
BlueCr																
P.O. Bo					T											
Elk Gro	18	13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscriber ID (SSN or ID#)							D (SSN or ID#)							
	┵															
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)							6. Plan/Group	Numbe	r '	17. Employer I	Name					
4. Dental? Medical? (If both, complete 5-11 for dental only.)																
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)								PATIENT INFORMATION								
								18. Relationship to Policyholder/Subscriber in #12 Above Use								
6. Date of Birth (MM/DD/CCYY) 7. Gender M F 8. Policyholder/Subscriber ID (SSN or ID#)						Self Spouse Dependent Child Other										
						20	0. Name (Last,	First, N	/liddle Initial,	, Suffix), Addre	ess, City,	State, Zip C	ode			
9. Plan/Group Number																
11. Other Insurance Company/De	ntal Benefit	Plan Name, Address,	City, State, 2	Zip Code		1										
						2	21. Date of Birth (MM/DD/CCYY)			22. Gender	2	23. Patient ID/Account # (As		signed by Dentist)		
										М	F					
RECORD OF SERVICES PR	OVIDED															
24 Procedure Date 25.	Area 26.	27. Tooth Numb	er(e)	28. Tooth	29. Proc	edure	29a. Diag.	29b.								
(MM/DD/CCVV) OIT	Oral Tooth vity System	or Letter(s)				е			30. Descript			otion		31. Fee		
1																
2																
3																
4																
5																
6																
7																
8														-		
9																
10 Nicola a Tauth Information (Dia	#24"			101	<u>.</u>		1110 115		//05.0	D 10D 10 1	5.		04 - 04	-		
		n each missing tooth.					Code List Qualifier		(ICD-9 = B; ICD-10 = AB)			31a. Other Fee(s)				
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 34a. Diagnosi							Code(s) A C									
32 31 30 29 28 27	26 25 2	24 23 22 21 2	0 19 18	17 (Pr	imary diag	nosis	ın " A ")	В		D			32. Total Fee			
35. Remarks																
AUTHORIZATIONS							CILLARY CI									
 I have been informed of the tre charges for dental services and 						38. F	Place of Treatm			1=office; 22=O/F) 39. Enci	losures (Y or N)			
law, or the treating dentist or de or a portion of such charges. To		(Use "Place of Service Codes for Professional Claims")														
of my protected health information	40. I	40. Is Treatment for Orthodontics? 41. Date Appliance Placed (MM/DD/CCYY)														
X		No (Skip 41-42) Yes (Complete 41-42)														
Patient/Guardian Signature		42. Months of Treatment Remaining 43. Replacement of Prosthesis 44. Date of Prior Placement (MM/DD/CCYY														
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly							Kemaining		No	Yes (Comp	olete 44)					
to the below named dentist or	45. T	Treatment Res	ulting fr	om												
x							Occupat	tional illi	ness/injury	Au	to accide	ent	Other accide	ent		
** 							46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State									
							TREATING DENTIST AND TREATMENT LOCATION INFORMATION									
submitting claim on behalf of the p	atient or ins	sured/subscriber.)				53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require										
48. Name, Address, City, State, Zi	p Code					n	multiple visits)	or have	been compl	leted.						
							X									
							Signed (Treating Dentist) Date									
						54. N						ense Number				
							6. Address, City, State, Zip Code				56a. Provider Specialty Code					
49. NPI	50. License	Number	51. SSN or	TIN							opecial	iy Code				
52. Phone	_	52a. Additio	nal			57. F	Phone () -		58. Add	litional				
Number \		Provid	or III)				Number \		,		Dr^	vider ID				