Excellus

A nonprofit independent licensee of the BlueCross BlueShield Association

165 Court Street
Rochester, NY 14647

UNIVERSITY OF ROCHESTER

Dental Claim Form

☐ Pre-Determination of Benefits ☐ Statement of Actual Services

Part I - Subscriber/ Patient Information

Subscriber's Full Name

Address

City, State, Zip Code

Is this a new address? ☐ Yes ☐ No

5. Subscriber Identification number (including ID prefix):

6. Is the patient covered by another dental plan?
☐ No (You are declaring that these services are not reimbursable under any other dental plan)
☐ Yes (Please complete the following section and, if appropriate, include your Explanation of Benefits)

Subscriber's Name | Date of Birth

Subscriber Identification Number

Name of Subscriber's Employer

Name of Other Dental Plan

1. Patient Name

2. Patient Date of Birth Mo Day Yr

3. Relationship to Subscriber Self Husband Wife Son Daughter Full Time College Student

4. I have reviewed the treatment plan. I authorize release of any information relating to the claim.

X _____ Signed (patient, or parent if minor) _____ Date

7. For services rendered out-of-area, I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.

X _____ Subscriber's signature _____ Date

Part II - Dentist Information

8. Dentist Name and 9. Mailing Address (city, state, zip)

10. Social Security or T.I.N.

11. License Number

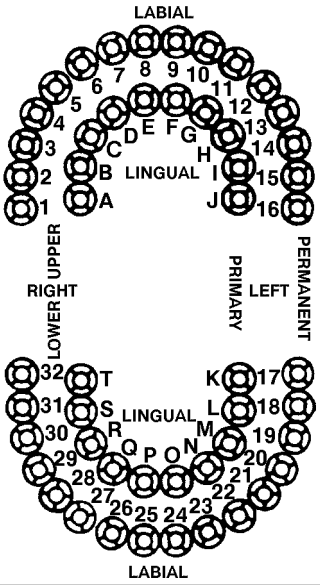
12. Phone Number

13. First visit date, current series Mo Day Yr

14. Radiographs or models enclosed? ☐ YES ☐ NO

	No	Yes	
Is treatment result of: 15. Occupational illness or injury? 16. Auto Accident? 17. Other accident?			If yes, enter brief description and dates:
18. Are any services covered by another plan?			If yes, enter name of other plan:
19. Has the patient ever had a previous prosthesis; fixed ☐ or removable ☐ ?			If yes, reason for replacement: / Date of prior placement
20. Is treatment for orthodontics?			If services already commenced enter: Total fee $ / Date appliances placed / Months of treatment remaining

Indicate missing teeth with an "X"



Tooth number or letter	Surfaces	Description of service	Date service performed Mo Day Yr	ADA procedure number	Fee	For Carrier Use Only
Remarks for unusual services				Total fee actually charged		

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.

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INSTRUCTIONS

If dental care is rendered by a dentist who has an agreement with BlueShield, the dentist will have a supply of claim forms in the office, will file claims and will receive payment directly from BlueShield.

If care is rendered by a dentist who does **not** have an agreement with BlueShield, payment for covered services will be made directly to the subscriber. In this case, it is the subscriber's responsibility to make payment arrangements with the dentist.

If the dentist practices outside of the Excellus BlueCross BlueShield operating area and the subscriber wishes direct payment to the dentist, Field 7 on this claim form must be signed and dated by the subscriber.

Pre-Determination of Benefits - A standard component of dental insurance programs is the Pre-Determination of benefits process. By checking the Pre-Determination box at the top of the claim form, and leaving the date of service blank, an estimate of the benefits allowable under the terms of the subscriber's contract can be made before services are rendered. In some cases, not all of the services in the dentist's treatment plan will be covered. **Allowed benefits do not infer disagreement with the treatment plan,** but merely contract limitations. The Pre-Determination is valid for 12 months from the date of issue.

It is the subscriber's responsibility to complete PART I of this claim form.

PART I

KEY TO SUBSCRIBER/PATIENT INFORMATION FIELDS:

Subscriber's Full Name,
Address, City, State, Zip Code

Field Number and Description:

1. Patient Name
2. Patient Date of Birth
3. Relationship to Subscriber
4. Patient/Subscriber Signature/Date
5. Subscriber Identification Number
6. Other Insurance Information*
7. Out-of-Area Payment Authorization

*Coordination of Benefits - It is not unusual to be covered by two insurance policies providing similar benefits. When this is the case, we will coordinate benefit payments with the other carrier. This prevents duplicate payments and overpayments. Field 6 **must** be answered or the claim form will be returned to the subscriber for the information before payment can be made.

PART II

KEY TO DENTIST INFORMATION FIELDS:

Field Number and Description:

8.-9. Dentist Name/Mailing Address
10. Social Security or T.I.N.
11. License Number
12. Phone Number
13. First Visit Date, Current Series
14. Radiographs or Models Enclosed?
15.-17. Is Treatment Result of:
18. Other Plan Coverage?
19. Previous Prosthesis Information
20. Is Treatment for Orthodontics?
    - Tooth Number or Letter
    - Surfaces
    - Description of Service
    - Date Service Performed
    - ADA Procedure Number
    - Fee
    - Dentist Signature and Date

Mail Completed Forms To: Excellus BlueCross BlueShield
PO Box 22999
Rochester, NY 14692

A separate claim form must be completed for each family member. If the claim form is not completed by both the subscriber and the dentist, the required information will be requested. This will delay processing of the claim.
If you need assistance to complete this form or require additional forms. . . .

SUBSCRIBERS and DENTISTS: Please call our Dental Service Representative at 1-800-724-1675.

TTY FOR THE HEARING IMPAIRED: 585-454-2845