





## PATIENT AND INSURED INSTRUCTION

We need all the information requested on the front of this form to process your claim. Please help us to serve you by filling in all the boxes asking for information about the patient and the subscriber on the upper part of the claim which includes items 1 through 20. Please print or type. **THIS NEW CLAIM FORM SUPPORTS IMAGING TECHNOLOGY WHICH WILL IMPROVE SERVICE TO OUR VALUED CUSTOMER.**

**IMPORTANT - COPY YOUR IDENTIFICATION NUMBER EXACTLY AS IT APPEARS ON YOUR IDENTIFICATION CARD.**

After filling in the upper part of the claim form, please give this form to your dentist who can fill in the lower part of the form which includes items 21 through 42.

## PATIENT'S SIGNATURE

The patient must sign the claim form, authorizing the release of information as described below. If the patient is a minor, the signature must be that of the patient's parent or legal guardian.

"I hereby authorize any dentist, physician, health care practitioner, hospital, clinic or other medical or dental related facility to furnish any and all records pertaining to dental or medical history, services rendered, or treatment given to me or my dependent for purposes of review, investigation or evaluation of this claim.

I also authorize Empire BlueCross BlueShield, or its agents, to disclose to a hospital or health care service plan, self-insurer or an insurer, any such dental or medical history information obtained if such disclosure is necessary to allow the processing of any claim.

If my coverage is under a group contract held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of this claim or terms of coverage of my insurance policy, including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon me, my heirs, executors or administrators."

## INSTRUCTIONS FOR ORTHODONTIC SERVICES

To facilitate processing of pretreatment estimates for Orthodontic services, the claim form should identify:

- Dates of service and fees for each procedure
- Monthly active treatment fee, date active treatment started, total number of months required
- Total fee charged
- Type of dentition, type of malocclusion, description of malocclusion
- Whether treatment is full or limited, type of appliance, treatment description

## INSURANCE FRAUD STATEMENT

PURSUANT TO REGULATION 95 OF THE NEW YORK STATE INSURANCE DEPARTMENT, "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, 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 SUCH VIOLATION."