

DENTAL CLAIM FORM																			
1. (CHECK ONE (✓)				2. PRIOR		RIZATIO							3. CARRIER NAME AND ADDRESS					
	□ DENTIST FEE TREA	ATMENT E	PATIEN	I ID NO								EMPIRE BLUECROSS BLUESHIELD DENTAL BENEFITS PROGRAMS							
	□ DENTIST STATEME	ENT OF AC												P.O.	BOX 791 IS, MN 55440-0791				
	4. PATIENT NAME	5 DELATI	5. RELATIONSHIP TO EMPLOYEE					6 959						FULL TIME STUDENT					
8	4. FATIENT NAME	□ SELF									7. PATIENT BIRTH DATE MONTH DAY YEAR			TOLL TIME STODENT					
F			□ SPOUSE □ SON				ı M		F					OOL CITY					
₩	9. EMPLOYEE/SUBS	OTHER	10. EMPLOYEE/SUBSCRIBER				11. EMPLOYEE/SUBSCRIBER				12. GROUP NUMBER			EMPLOYER NAME AND ADDRESS					
6	o. Elvii Eo l'EE/oobo		IDENTIFICATION NUMBER				BIRTH DATE MONTH DAY YEAR				TE. GROOF HOMBER			EMI EO TERTAMINE AND ADDRESS					
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띮	14. IS PATIENT COV	L 15-A. NAM	15-A. NAME AND ADDRESS OF OTH					HER CARRIER(S)				NUMBER(S	i) 16. C	THER PLAN-EMPLOYER NAME/ADD	RESS				
Š	PLAN? ☐ YES ☐ IS PATIENT COV																		
C	YES NO	17 D. OTI	17-B. OTHER PLAN-SUBSCRIBER ID					DENTIFICATION NI IMPER				IDED DIDTIL	DATE 10 F	RELATIONSHIP TO PATIENT					
EN	(IF DIFFERENT	17-B. OTF	17-b. OTTENT EAN-SUBSCRIBERTO				DENTIFICATION NUMBER					DAY YEA							
PAT														□ SPOUSE □ SON □ OTHER					
	I HAVE REVIEWED TH	 T PLAN AND FE	AN AND FEES. I AGREE TO BE				20. I HEREBY AUTHORIZE PA				IT OF	THE DENTA		S OTHERWISE PAYABLE TO ME	_				
	RESPONSIBLE FOR A ANY INFORMATION R				ATMENT. I AUT	HORIZE	RELEA	SE OF	DII	RECTL	Y TO T	HE BEI	LOW NAM	MED D	ENTIST ENT	ITY.			
	ANT IN CHIMATION II	ILLATED	0 11110 0	JEANVI.															
PATIENT SIGNATURE DATE									SI	JRE (E	MPLOY	/EE/SUBS	CRIBI	ER)		DATE			
21. NAME OF BILLING DENTIST OR DENTAL ENTITY									30. IS TREATMENT RESULT				LT NO	YES IF YES, ENTER DE			RIPTION AND DATE		
ETES										OF OCCUPATIONAL ILLNESS OR INJURY?									
블	22. ADDRESS WHER	RE PAYME	NT SHO	ULD BE R	EMITTED					31. IS TREATMENT RESUL									
COMPLI									OF	OF AUTO ACCIDENT?									
TC	23. CITY, STATE, ZII					32. OT	32. OTHER ACCIDENT?												
DENTIST																			
	24. DENTIST SSN O	LICENSE NO.	ENSE NO. 26. PHONE NUMBER				33. IF PROSTHESIS, IS IT INITIAL PLACEMENT?					IF NO, REA		34. DATE OF PRIOR PLACEMEN	Т				
NG				1	1														
BILLING	27. 1ST VISIT	28. PLAC			RADIOGRAPH OR MODELS	IS NO	YES	HOW MANY?	35. IS TREATMENT FOR ORTHODONTICS?						DATE APP PLACED?	LIANCES	MISC. TREATMENT REMAINING?	,	
	ECF O OTHER O			ENCLOSED?															
36. IDENTIFY MISSING TEETH WITH "X" 37. EXAMINATION AND TREATMENT PLAN														FOR					
ကြိုက်လုံ												ADMINISTRATIVE USE ONL'	<u>′</u>						
	TOOTH SURF				DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAX									PROCEDURE NUMBER					
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39.	I HEREBY CERTIFY T SUBMITTED ARE THE	HAT THE F	PROCEDI FEES I H	URES AS AVE CHA	INDICATED BY RGED AND INT	DATE H	IAVE BE	EN COMP	PLETED HOSE P	AND T	HAT TH	HE FEE	S	41. T	OTAL FEE C	HARGED			
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s	IGNED (TREATING DE		LI	CENSE NI	UMBER	MBER DATE				IVIAX A	ALLOWABLE								
40.	ADDRESS WHERE TR	REATMEN	T WAS PI	ERFORM	ED									DEDU	CTIBLE				
														CARR	IER %				
CITY STATE ZIP CODE												PATIE	NT PAYS						
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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."