blue california

Dental claim form

Blue Shield of California and
Blue Shield of California Life & Health Insurance Company

Submit Dental Claims To: Blue Shield, P.O. Box 272590, Chico, CA 95927-2590

Blue Shield use only	**IMPORTANT: Treatment plans exceeding $250.00 should be submitted for precertification. Failure to do so may result in patient responsibility for claims subsequently adjusted or denied.**

Patient/subscriber information

1. Patient name	2. Relationship to employee Self | Spouse/Domestic Partner | Child | Other	3. Sex M | F	4. Patient birthdate Month Day Year	5. If full time student School | City

6. Employee/ subscriber name	First Initial Last	7. Employee/subscriber no. (see dental ID card)
8. Mailing address, street, city, state, ZIP code		9 -12. Employee/subscriber group no. and/or group name
13. Are other family members employed?	Employee name SSN #	14. Name and address of employer in item 13
15. Is patient covered by another dental plan?	Dental plan name Union local	Policy no. Name and address of carrier

Dentist information

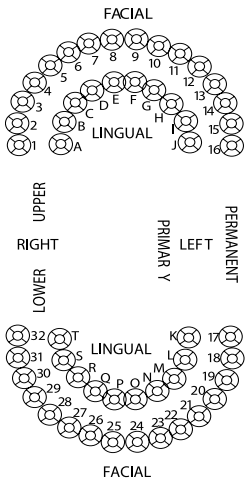
16. Dentist SS# or T.I.N.	17. Dentist license no.	18. Dentist phone no.	19. Dentist's name, address, city, state, ZIP code
20. Provider ID			

21. First visit date of current series	22. Place of treatment Office | Hospital | ECF | Other	23. Radiographs or models enclosed? Yes | No | How many?	27. If prosthesis/ crown is this initial placement? Yes / No	If no, the reason for replacement	28. Date of prior placement

24. Is treatment result of occupation illness or injury? Yes / No	If yes, enter brief description and dates	29. Is treatment for orthodontics? Yes / No	If services already commenced enter: Date appliances placed Months of treatment remaining
25. Is treatment result of auto accident? Yes / No		I hereby certify that the services listed have been or will be provided by me.	
26. Other accident? Yes / No		Dentist's Signature Date	

30. Examination and treatment plan — List in order from tooth no. 1 through tooth no. 32

Identify missing teeth with "X"



Tooth no. or letter	Surface	Description of service (Including x-rays, prophylaxis, materials used etc.)	Date service performed MO	DAY	YEAR	ADA procedure number	Fee	Blue Shield use only Allowed amount
						Total Fee Actually Charged		

Remarks:

31. Patient's authorization: I have been informed of the treatment plan and associated fees identified above, and, to the extent permitted by law, I authorize the release of information relative to this course of treatment and to the payment activities in connection with this claim.

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. I understand that I am responsible for the charges for any service not approved by benefit pre-certification review, or are rendered during any ineligible period and for the co-payments, deductibles and amounts exceeding the calendar year maximum of my dental plan. I understand that I may request a copy of any precertification review determination from Blue Shield.

32. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the above named dentist or dental entity.

Signed (patient or guardian if minor) Date

Subscriber/member signature Date

For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.