



An Independent Licensee of the Blue Cross and Blue Shield Association

**TO BE COMPLETED BY SUBSCRIBER**

1. Patient Name <input style="width:100%;" type="text"/>		2. Relationship to Employee Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		3. Sex Male <input type="checkbox"/> Female <input type="checkbox"/>		4. Patient Birthdate Month <input type="text"/> Day <input type="text"/> Year <input type="text"/>			5. If Full Time Student Give School Name and City <input style="width:100%;" type="text"/>			
6. Employee/Subscriber Name (Last Name, First Name, M.I.) <input style="width:100%;" type="text"/>						7. Contract Number <input style="width:100%;" type="text"/>						
8. Employee/Subscriber Mailing Address <input style="width:100%;" type="text"/> City, State, Zip <input style="width:100%;" type="text"/>						9. Employer (Company) Name and Address <input style="width:100%;" type="text"/> City, State, Zip <input style="width:100%;" type="text"/>						
10. Group Number <input style="width:100%;" type="text"/>		11. Division Number <input style="width:100%;" type="text"/>		12. Is patient covered by another dental plan? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, complete the following:		Name of Policy Holder <input style="width:100%;" type="text"/>			Policy or Contract No. <input style="width:100%;" type="text"/>			
Dental Plan Name <input style="width:100%;" type="text"/>				Group Number <input style="width:100%;" type="text"/>		Name and Address of Carrier <input style="width:100%;" type="text"/>						
13. I have reviewed the following treatment plan. I authorize release of any information relating to this claim. <input style="width:100%; height: 20px;" type="text"/>											Pay Subscriber <input type="checkbox"/>	Pay Dentist <input type="checkbox"/>
Signed (Patient, or Parent, if Minor)											Date	

**TO BE COMPLETED BY DENTIST**

14. Dentist Name <input style="width:100%;" type="text"/>		21. Is treatment result of occupational illness or injury? No <input type="checkbox"/> Yes <input type="checkbox"/>		If yes, enter brief description and dates. <input style="width:100%;" type="text"/>	
15. Mailing Address <input style="width:100%;" type="text"/> <input style="width:100%;" type="text"/> City, State, Zip <input style="width:100%;" type="text"/>		22. Is treatment result of auto accident? Other accident? <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
16. Dentist So. Sec. or T.I.N. <input style="width:100%;" type="text"/>		17. Dentist Phone Number <input style="width:100%;" type="text"/>		18. Plan Code/Provider Number <input style="width:100%;" type="text"/>	
19. Radiographs or models enclosed? No <input type="checkbox"/> Yes <input type="checkbox"/> How many? <input type="text"/>		24. <input type="checkbox"/> Actual Services <input type="checkbox"/> Predetermination			
23. If prosthesis, is this initial placement? <input type="checkbox"/> <input type="checkbox"/>					
				If no, reason for replacement <input style="width:100%;" type="text"/>	
				Date of prior placement <input style="width:100%;" type="text"/>	

<p>Identify Missing Teeth With "X"</p>	25. Examination & Treatment Plan – List in order from Tooth #1 through Tooth #32 – Use Charting System Shown								
	Tooth #, Letter or Quadrant	Surface	Description Of Service (Including X-Rays, Prophylaxis, Materials Used, Etc.) Line Number	Date Service Performed Month Day Year			Procedure Number	Fee	For Administrative Use Only
			1.						
			2.						
			3.						
			4.						
			5.						
			6.						
			7.						
			8.						
			9.						
		10.							

26. I hereby certify that the procedures as indicated by date have been completed. <input style="width:100%;" type="text"/>		Date		TOTAL FEE CHARGED <input style="width:100%;" type="text"/>			
Signed (Dentist or Legal Representative)							