MEMBER DENTAL CLAIM FORM

HIGHMARK WESTERN NEW YORK
Trade name of Highmark Western and Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield Association

Clear Form

Please submit claim to:
Dental Claims
P.O. Box 69421
Harrisburg, PA 17106-9421

HEADER INFORMATION

1. Type of Transaction (*Mark all applicable boxes*)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Highmark BC BS Freedom Nation Plan (PPO)
Highmark Blue Cross Blue Shield of WNY
257 West Genesee Street
Buffalo, NY 14202

OTHER COVERAGE (Mark applicable box and complete 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (if both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (*Last, First, Middle Initial, Suffix*)

6. Date of Birth (*MM/DD/CCYY*)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (*MM/DD/CCYY*)	14. Gender ☐ M ☐ F	15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number	17. Employer Name	

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other	19. Reserve For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (*MM/DD/CCYY*)	22. Gender ☐ M ☐ F	23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) A _____ C _____
(Primary diagnosis in "A") B _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. 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. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

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

X _____
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")	39. Enclosures (Y or N) ☐ Yes ☐ No
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)	41. Date Appliance Placed (*MM/DD/CCYY*)
42. Months of Treatment Remaining:	43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) / 44. Date of Prior Placement (*MM/DD/CCYY*)

45. Treatment Resulting from
☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)	47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI	50. License Number	51. SSN or TIN
52. Additional Provider ID	52a. Phone Number ( ) -	

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI	55. License Number
56. Address, City, State, Zip Code	56a. Provider Specialty Code
57. Phone Number ( ) -	58. Additional Provider ID

Notice of Nondiscrimination

The plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call the customer service number on the back of your member ID card or contact the Civil Rights Coordinator.

If you believe that the plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295 (TTY 711), Fax: 1-412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org

You can file a grievance in person or by mail, fax, or email. You can also file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at US Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

For assistance in English, call the customer service number listed on your member ID card.

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

.פאר הילף אין אידיש, רופט די קאסטומער סערוויס אויפן נומער וואס שטייט אויף אייער ID קארטל

বাংলায় সহায়তার জন্য, আপনার আইডি কার্ডে তালিকাভুক্ত নম্বরে ক্রেতা পরিষেবায় ফোন করুন।

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

اردو میں مدد کے لیے، کسٹمر سروس آپ کے شناختی کارڈ پر درج کردہ نمبر پر کال کریں

Pour une assistance en français, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

اردو زبان میں مدد کے لئے، کسٹمر سروس کو اپنے آئی ڈی کارڈ پر درج نمبر پر کال کریں۔

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Για βοήθεια στα ελληνικά, καλέστε το τμήμα εξυπηρέτησης πελατών στον αριθμό που αναφέρεται στην ταυτότητά σας.

Për ndihmë në gjuhën shqipe, merrni në telefon shërbimin klientor në numrin e renditur në kartën tuaj të identitetit.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

Diné k´ehjí yá´áti´bee shíká adoowot nohsingo naaltsoos nihaa halne´go nidaahtinígíí bine´déé´ Customer Service bibéésh bee hane´é biká'ígíí bich´j´dahodootnih.

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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 subjects such person to criminal and civil penalties.