BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.®

ATTENDING DENTIST'S STATEMENT

CHECK ONE: USE ONE FORM PER CLAIM

☐ PRE-TREATMENT ESTIMATE ☐ STATEMENT OF ACTUAL SERVICES

MAIL TO: BLUE CROSS AND BLUE SHIELD OF ILLINOIS
POST OFFICE BOX 23059
BELLEVILLE, ILLINOIS 62223-0059

PATIENT INFORMATION

1. PATIENT NAME FIRST / M.I. / LAST	2. RELATIONSHIP TO EMPLOYEE ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER	3. SEX ☐ M ☐ F	4. PATIENT BIRTH DATE MO. / DAY / YEAR	5. IF FULL-TIME STUDENT SCHOOL / CITY

6. EMPLOYEE/SUBSCRIBER NAME AND MAILING ADDRESS	7. EMPLOYEE/SUBSCRIBER IDENTIFICATION NUMBER	8. EMP/SUB BIRTH DATE MO. / DAY / YEAR

9. EMPLOYER (COMPANY) NAME AND ADDRESS	10. GROUP NO.	11. IS PATIENT COVERED BY ANOTHER PLAN? IF YES, COMPLETE BOXES 12A THRU 15. DENTAL: ☐ YES ☐ NO MEDICAL: ☐ YES ☐ NO

12-A. NAME AND ADDRESS OF CARRIER(S)	12-B. GROUP NUMBER(S)

13. NAME AND ADDRESS OF EMPLOYER	14-A. OTHER EMPLOYEE/SUBSCRIBER NAME (IF DIFFERENT THAN PATIENT'S)

14-B. EMPLOYEE/SUBSCRIBER IDENTIFICATION NUMBER	14-C. EMPLOYEE/SUBSCRIBER BIRTH DATE MO. / DAY / YEAR	15. RELATIONSHIP TO PATIENT ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER

I UNDERSTAND THAT BLUE CROSS AND BLUE SHIELD'S USE OR DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION, WHETHER FURNISHED BY ME OR OBTAINED FROM OTHER SOURCES SUCH AS MEDICAL PROVIDERS, SHALL BE IN ACCORDANCE WITH THE FEDERAL PRIVACY REGULATIONS UNDER HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996). I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

SIGNED (PATIENT, OR PARENT IF MINOR) DATE

I HEREBY AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THE BELOW NAMED DENTAL ENTITY.

SIGNED (INSURED PERSON) DATE

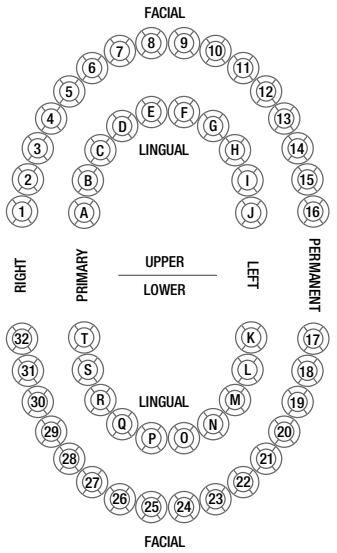
DENTIST INFORMATION

16. DENTIST NAME	17. MAILING ADDRESS	CITY / STATE / ZIP	18. DENTIST SOC. SEC. NO. OR TIN	19. DENTIST LICENSE NO.	20. DENTIST PHONE

21. FIRST VISIT DATE CURRENT SERIES	22. PLACE OF TREATMENT OFFICE/HOSP./ECF/OTHER	23. RADIOGRAPHS OR MODELS ENCLOSED? ☐ YES ☐ NO HOW MANY?

	NO	YES	
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			IF YES, ENTER BRIEF DESCRIPTION AND DATES
25. IS TREATMENT RESULT OF AUTO ACCIDENT?			
26. OTHER ACCIDENT?			
27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) DATE OF PRIOR PLACEMENT
29. IS TREATMENT FOR ORTHODONTICS?			IF YES, DATE APPLIANCE PLACED: MOS. TREATMENT REMAINING:

IDENTIFY MISSING TEETH WITH "X"



30. EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO.32 - USE CHARTING SYSTEM

TOOTH # OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICES PERFORMED	PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THAT THE FEES SUBMITTED ARE THE ACTUAL FEES I HAVE CHARGED AND INTEND TO COLLECT FOR THOSE PROCEDURES.

SIGNED (TREATING DENTIST)

LICENSE NUMBER DATE

REMARKS FOR UNUSUAL SERVICES

TOTAL FEE CHARGED		
PAYMENT BY OTHER PLAN		
MAX ALLOWABLE		
DEDUCTIBLE		
CARRIER %		
CARRIER PAYS		
PATIENT PAYS		

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PLEASE REVIEW BEFORE SUBMITTING CLAIM

INFORMATION FOR PATIENT

1. Complete items one (1) through fifteen (15) in full to assist with positive identification and prompt payment. Please print or type. Your group and Subscriber Identification number can be found on your Blue Cross and Blue Shield ID card.

2. You must sign the claim form under the Patient Information section indicating that the information is correct and authorizing payment.

3. The patient (or parent, if the patient is a minor) must sign the "Authorization to Release Information".

4. If total charges for the planned course of treatment can reasonably be expected to be $300 or more, it is recommended that a pre-treatment estimate be submitted prior to the commencement of the course of treatment. Blue Cross will notify you and your dentist of benefits payable.

   Estimated benefits are subject to your coverage being in force at time services are performed and are subject to the specific limitations and exclusions listed in your benefit plan.

   Please refer to your Certificate of Coverage for a description of covered services, percentage of fees payable, limitations and exclusions.

   The completed form should be mailed to the address shown below.

   NOTE: Any person who knowingly presents false, incomplete or misleading information is guilty of a crime and is subject to a fine or imprisonment or both.

INFORMATION FOR ATTENDING DENTIST

1. Complete items 16 through 28 and item 29 on the claim form.

2. If total charges for the planned course of treatment can reasonably be expected to be $300 or more, it is recommended that a pre-treatment estimate be submitted prior to the commencement of the course of treatment. Blue Cross will notify you and your patient of benefits payable.

   You and your patient are free to pursue any treatment plan mutually agreed upon. Pre-estimation of benefits is only intended to avoid any misunderstanding among the patient, the dentist, and Blue Cross and Blue Shield, concerning the benefits allowed under terms of the coverage.

3. Generally, radiographs will not be required when submitting a claim. However, pre-operative radiographs may be requested in certain situations for dental consultant use in benefit determination.

4. If the subscriber has so authorized, benefit payment will be made directly to you.

   NOTE: Any person who knowingly presents false, incomplete or misleading information is guilty of a crime and is subject to a fine or imprisonment or both.

Mail Completed Form to: Blue Cross and Blue Shield of Illinois
Post Office Box 23059
Belleville, Illinois 62223-0059