

INSTRUCTIONS

If dental care is rendered by a dentist who has an agreement with BlueShield, the dentist will have a supply of claim forms in the office, will file claims and will receive payment directly from BlueShield.

If care is rendered by a dentist who does **not** have an agreement with BlueShield, payment for covered services will be made directly to the subscriber. In this case, it is the subscriber's responsibility to make payment arrangements with the dentist.

If the dentist practices outside of the Excellus BlueCross BlueShield operating area and the subscriber wishes direct payment to the dentist, Field 9 on this claim form must be signed and dated by the subscriber.

Pre-Determination of Benefits - A standard component of dental insurance programs is the Pre-Determination of benefits process. By checking the Pre-Determination box at the top of the claim form, and leaving the date of service blank, an estimate of the benefits allowable under the terms of the subscriber's contract can be made before services are rendered. In some cases, not all of the services in the dentist's treatment plan will be covered. **Allowed benefits do not infer disagreement with the treatment plan**, but merely contract limitations. The Pre-Determination is valid for 12 months from the date of issue.

It is the subscriber's responsibility to complete PART I of this claim form.

PART I

KEY TO SUBSCRIBER/PATIENT INFORMATION FIELDS:

Subscriber's Full Name, Address, City, State, Zip Code	REQUIRED (Unless pre-printed)
Field Number and Description:	
1.-2. Subscriber Birthdate/Hire Date	OPTIONAL
3. Patient Name	REQUIRED
4.-5. Patient Date of Birth/Relationship to Subscriber	REQUIRED
6. Patient/Subscriber Signature/Date	OPTIONAL
7. Subscriber Identification Number	REQUIRED
8. Other Insurance Information*	REQUIRED
9. Out-of-Area Payment Authorization	WHEN APPLICABLE

*Coordination of Benefits - It is not unusual to be covered by two insurance policies providing similar benefits. When this is the case, we will coordinate benefit payments with the other carrier. This prevents duplicate payments and overpayments. Field 8 **must** be answered or the claim form will be returned to the subscriber for the information before payment can be made.

PART II

KEY TO DENTIST INFORMATION FIELDS:

Field Number and Description:	
10.-11. Dentist Name/Mailing Address	REQUIRED
12. Social Security or T.I.N.	WHEN APPLICABLE
13. License Number	OPTIONAL
14. Phone Number	OPTIONAL
15. First Visit Date, Current Series	WHEN APPLICABLE
16. Radiographs or Models Enclosed?	WHEN APPLICABLE
17.-19. Is Treatment Result of:	WHEN APPLICABLE
20. Other Plan Coverage?	WHEN APPLICABLE
21. Previous Prosthesis Information	WHEN APPLICABLE
22. Is Treatment for Orthodontics?	WHEN APPLICABLE
- Tooth Number or Letter	WHEN APPLICABLE
- Surfaces	WHEN APPLICABLE
- Description of Service	REQUIRED
- Date Service Performed	WHEN APPLICABLE
- ADA Procedure Number	REQUIRED
- Fee	REQUIRED
- Dentist Signature and Date	REQUIRED

Mail Completed Forms To: Excellus BlueCross BlueShield
PO Box 22999
Rochester, NY 14692

A separate claim form must be completed for each family member. If the claim form is not completed by both the subscriber and the dentist, the required information will be requested. This will delay processing of the claim. If you need assistance to complete this form or require additional forms. . . .

SUBSCRIBERS and DENTISTS: Please call our Dental Service Representative at: regarding Rochester subscribers, 1-800-724-1675; regarding CNY and CNY Southern Tier subscribers, 1-800-233-0384

TTY FOR THE HEARING IMPAIRED: Rochester 585-454-2845 CNY and CNY Southern Tier 315-448-6764