Dental Claim Form

1.
- ☐ Pretreatment Estimate
- ☐ Statement of Services
- ☐ NPI #

2. Carrier name and address
Blue Cross and Blue Shield of Montana
P.O. Box 6227
Helena, MT 59604

PATIENT COVERAGE INFORMATION

3. Patient Name
first m.i. last

4. Relationship to Member
☐ Self ☐ Child ☐ Spouse ☐ Other

5. Sex
☐ M ☐ F

6. Patient birth date
mm dd yy

7. Member Name and Mailing Address

8. Member ID #

9. Member birth date
mm dd yy

10. Employer Name
Group #

11. Other Coverage
☐ Yes ☐ No
Yes completes 11a.
Coverage by a medical plan
☐ Yes ☐ No

11a. Name and Address of Carrier(s)

12. I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless 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 under applicable law, I authorize release of any information relating to this claim.

> _____ _____
Signed (Patient) Date

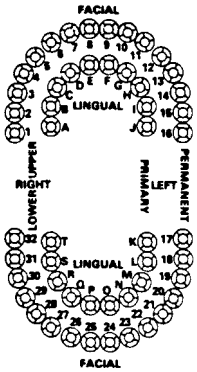
13. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

> _____ _____
Signed (Member) Date

BILLING DENTIST

14. Name of Billing Dentist or Dental Entity		15. Is treatment the result of an occupational illness or injury?	No	Yes	Description	
16. Address where payment to be remitted		17. Is treatment the result of an automobile accident?				
18. City, State, Zip		19. Other accident?				
20. SSI or TIN	21. Phone Number	22. If prosthesis, is this initial replacement?			No, reason for replacement	Prior Placement Date
23. First visit date current series	24. Place of Treatment: Office Hosp ECF Other	25. Radiographs / Models enclosed? N Y #	26. Is treatment for orthodontics?		Service already commenced enter	Date Appl. Place / Mos. Remaining

27. Identify Missing Teeth with X



28. Examination and Treatment Plan – List in order from tooth no. 1 – tooth no. 32 – Using charting system shown

Tooth # or letter	Surface	Description of Service (including x-rays, prophylaxis, materials used, etc.)	Date of Service Mo	Day	Year	Procedure Code	Fee	Administrative use only

29. Remarks for unusual services

30. 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) Date

33. Address, city, state, zip where treatment was performed

31. Total Fee Charged		
32. Payment by Other Plan		
Max Allowable		
Deductible		
Carrier %		
Carrier Pays		
Patient Pays		

BCBSMT DENTAL CLAIM FORM\FORMS

White Copy: To Be Forwarded to BCBSMT **Yellow Copy**: Provider **Pink Copy**: Patient

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