Check One:

☐ Dentist's Request For **Predetermination**
☐ Dentist's Statement of **Actual Services**
☐ Authorization Number
(Important: See claim processing criteria on back of form.)

Attending Dentist's Statement

Mail To:
Blue Cross and Blue Shield of Texas
P.O. Box 660247 Dallas, Texas 75266-0247
Telephone (972) 766-3077

BlueCross BlueShield of Texas

1. Patient Name
First Middle Last

2. Relationship To Employee
Self ☐ Spouse ☐ Child ☐ Other ☐

3. Patient Sex
Male ☐ Female ☐

4. Patient Birthdate
Mo ____ / Day ____ / Year ____

5.

6. Employee/Subscriber Name
First Middle Last

7. **Employee/Subscriber Identification Number**

7a. **Group Number**

8. Employee/Subscriber Mailing Address

9.

10. Employer (Company) Name

City, State, ZIP

10a. Employer (Company) Address

11.-14.

15. **Coordination Of Benefits** Is patient covered under any other dental plan? ☐ Yes ☐ No

Insuring Co. ______________________ Policy # ______________________ Month Day Year

Address ______________________ Effective Date of Coverage _____ /_____ /_____

Employer ______________________ Sex ☐ Male ☐ Female Birthdate _____ /_____ /_____

Insured ______________________ Relationship to Patient ______________________

If The Other Insurance Is Primary, Attach The Other Company's Explanation Of Benefits.

I Have Reviewed The Following Treatment Plan.
I Authorize Release Of Any Information Relating To This Claim.

Make Payment To: (Check One) ☐ Employee/Subscriber (Include Current Address)
☐ Dentist (Include Blue Cross and Blue Shield of Texas Provider Account No. To Receive Payment)

______________________ ______________
Signed (Insured Person) Date

16. Dentist Name

24. Is Treatment Result Of Occupational Illness Or Injury? No Yes — If Yes, Enter Brief Description And Dates.

17. Mailing Address

Blue Cross and Blue Shield of Texas Provider Account No.

25. Is Treatment Result of Auto Accident? No Yes

27. Date of Accident _____ /_____ /______

City, State, ZIP

26. Other Accident? No Yes

18. Dentist Tax I.D. No.

19. Dentist License No.

20. Dentist Phone No.

28. If Prosthesis, Is This Initial Placement? No Yes (If No: Reason For Replacement)

29. Date Of Prior Placement

21. First Visit Date Current Series

22. Place Of Treatment: Office ¦ Hosp ¦ ECF ¦ Other

23. Radiographs Or Models Enclosed? No Yes How Many?

30. Is Treatment For Orthodontics? No Yes — If Services Already Commenced, Enter: Date Appliances Placed, Mos. Treatment Remaining

Identify Missing Teeth With X

Facial
Upper Right / Lower — Lingual — Primary — Permanent — Left
Teeth 1–32, A–T
Facial

31. Examination And Treatment Plan List In Order From Tooth No. 1 Through No. 32 Use Charting System Shown

Tooth # Or Letter	Surface	LINE	Description of Service (Including X-Rays, Prophylaxis, Materials Used, Etc.)	Date Service Performed (Completed) Mo Day Year	Procedure Number	Fee	For Office Use Only
		1			0		
		2			0		
		3			0		
		4			0		
		5			0		
		6			0		
		7			0		
		8			0		
		9			0		
		10			0		
		11			0		
		12			0		
		13			0		
		14			0		
		15			0		
						Total Fee Charged	

32. Remarks For Unusual Services

33. Address where treatment was performed
____
____
____

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 these procedures.

Signed (Dentist) ______________________ Date______________

These insurance benefits will, subject to contract provisions, be payable if the described procedures are performed during a period of the patient's eligibility.

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

PREDETERMINATION OF BENEFITS

Predetermination allows all parties concerned to become acquainted with the entire treatment plan, its charges, and Blue Cross and Blue Shield's responsibility for benefits prior to actual services being rendered. This eliminates many misunderstandings about the extent of the insurance coverage. Blue Cross and Blue Shield will be glad to cooperate with the dental provider or the employee/subscriber on any matters related to Predetermination of fees.

A description of the procedure (including codes) to be performed and the dentist's charges may be filed with the carrier for Predetermination of Benefits allowable based on the contract benefits and limitations as well as Blue Cross and Blue Shield's determination of the allowable amount when applicable. Predetermination is not provided for Federal Employee Program (FEP) or other fixed fee schedule programs.

After submitting the treatment plan to Blue Cross and Blue Shield, you will receive a Predetermination form indicating the specific contract benefits for each procedure on your treatment plan. When you have completed your treatment plan, enter the date that each service was completed and return the signed Predetermination form to the address as shown.

TO BE COMPLETED BY EMPLOYEE

Item	Description	Instructions
1-4	Patient's name, birthdate, sex and relationship of patient to employee.	Use patient's full name (NO NICKNAMES, please). All items must be completed for claims processing.
5	Student	Not applicable.
6-8	Employee's name, address and identification number or "R" number for federal employees as shown on identification card.	Please show the employee's name and identification number exactly as it appears on the Blue Shield (Dental or FEP) identification card and specify the current address including the ZIP Code.
7a	Group number as shown on identification card.	Give the group number as it appears on the employee's/subscriber's Blue Cross and Blue Shield (or other) Dental Contract identification card.
9	Blue Cross - Blue Shield - FEP or other	Circle FEP if this is a Federal Employee Program claim.
10	Employer's name and address	
11 - 14	Employment of other family members.	Refers to any family member (wife, son, daughter or other dependent) who is employed elsewhere and who may have dental coverage. Give name and address of other employer.
15	Other group insurance.	Is the patient covered by another dental plan? If yes, please complete the remainder of No. 15.

TO BE COMPLETED BY DENTIST

Item	Description	Instructions
16 - 17	Dentist's name, account (provider) number and current mailing address.	Give the dentist's name, include the Blue Cross and Blue Shield Dental (provider) account number. Indicate the dentist's current mailing address.
18	Dentist's social security or tax identification number	The Internal Revenue Service code requires this information be supplied if the provider accepts an assignment. This is not necessary if there is a Blue Cross and Blue Shield provider number.
19 - 20	Dentist's license number and phone number.	Dentist's license number is frequently used as a means of identifying legal providers. Include area code with dentist's telephone number.
21 - 22	First visit date and place of treatment.	List the first visit date (current series). Indicate the place of treatment - hospital, office or other.
23	Radiographs or models enclosed.	This space indicates whether or not such diagnostic materials were submitted and how many, so that proper items are returned to the dentist.
24 - 26	Is treatment the result of occupational illness or injury, auto accident, or other?	Treatment result of occupational illness or accident refers to possible application of workers' compensation. If treatment is a result of auto accident, this could affect reimbursement in no-fault auto insurance cases.
27	Date of accident.	Date of accident must be indicated.
28 - 29	Prosthesis (includes crowns, bridges, partials and dentures).	Please indicate if this is initial placement and if not, give date of prior placement.
30	Orthodontics	Enter the requested information regarding orthodontic treatment if applicable.
31	Examination and treatment plan.	List your examination and treatment plan using the American Dental Association code and Dental procedure nomenclature (as revised).
32	Remarks	Enter any remarks pertaining to unusual or complex services performed or reasons for a greater than usual fee. For consideration of four quadrants of scaling and root planing performed on the same date, please attach periodontal charting and length of treatment time. If this documentation is missing, the claim will be recoded to 04340 (full mouth scaling and root planing). Please attach additional pages as necessary.
33	Physical Address	Actual address where treatment was rendered.

DENTIST PLEASE NOTE: If there is a disagreement with the payment or predetermination, a re-evaluation from Blue Cross and Blue Shield of Texas can be requested or assistance may be obtained from the dentist's local Dental Society Peer Review Committee. ANY INQUIRY CONCERNING THIS CLAIM OR SUPPLEMENTAL INFORMATION MUST INCLUDE MEMBER'S FULL NAME, PATIENT'S FULL NAME AND THE GROUP AND CERTIFICATE NUMBERS.