DentalBlue

DENTAL CLAIM FORM

BC & BS Use Only
Claim Number:

Attending Dentist's Statement

☐ **Statement of Actual Services.** ☐ **Pretreatment Estimate.** **(Check One)**

1. Patient's Name:	2. Sex: Male Female	3. Patient's Birthdate:
4. Relationship to Employee: Self Spouse Child Student Handicapped	5. If Full-Time Student, School and City:	
6. Employee (Subscriber) Name: First Initial Last	7. Subscriber ID Number:	
8. Employee (Subscriber) Mailing Address: City State Zip Code	9. Employer (Company) Name:	
10. Is Parent Covered by Another Dental Plan?: ☐ No ☐ Yes Dental Plan Name:	Union Local: Group No.:	Name a nd Address of Carrier:

I have reviewed the following treatment plan. I authorize the release of any information relating to this claim.

Signed (Patient or parent if a minor): Date:

*** To be completed by Dentist, or attach an itemized superbill.**

11. Dentist's Name Mailing Address City State Zip Code			
12. Dentist's Social Security No.:	13. Provider Number:	14. Dentist's Phone Number:	15. First Visit Date - Current Series:
16. Place of Treatment: ☐Office ☐Hosp. ☐ECF ☐Other	17. Radiographs or Models Encl.?: ☐ No ☐ Yes, How Many? ____	18. Is treatment result of occupational illness or injury?: ☐ No ☐ Yes If yes, enter brief descr. and dates: ____	
19. Is treatment result of auto accident?: ☐ No ☐ Yes If yes, enter brief descr. and dates: ____	20. Other accident?: ☐ No ☐ Yes If yes, enter brief descr. and dates: ____		
21. Are any services covered by another plan:? ☐ No ☐ Yes If yes, enter brief descr. and dates: ____	22. If prosthesis, is this the initial placement?: ☐ No ☐ Yes If no, reason for replacement: ____	23. Date of Prior Placement:	
24. Is treatment for orthodontics?: ☐ No ☐ Yes If services already commenced, enter Date Appliances Placed: ____ Months of Treatment Remaining: ____			

TOOTH # OR LETTER	SURFACE (ie: MO DBLIG)	DESCRIPTION OF SERVICE (including X-rays, Prophylaxis, Materials Used, Etc.)	DATE SERVICE PERFORMED MM DD YY	PROCEDURE CODE NUMBER	DENTIST'S FEE	INTERNAL CODE	CREDIT TOWARD DENTIST'S FEE	LOCATION	UNIT	LINE ITEM
				0	.00			1	01	1
				0	.00			1	01	2
				0	.00			1	01	3
				0	.00			1	01	4
				0	.00			1	01	5
				0	.00			1	01	6
				0	.00			1	01	7
				0	.00			1	01	8
				0	.00			1	01	9
		Total Fee Actually Charged			.00		Disp. Code 1	Payee Code 1		

Dentist's Statement: I hereby certify the services listed have been or will be provided by me.

Dentist's Signature Date

Claims for crowns, inlays and onlays should include preoperative X-rays.

*** Please Note: Predetermination of benefits does not guarantee payment.**

Pretreatment estimates are calculated based on current available benefits and the patient's eligibility. Estimates are subject to modification based upon remaining benefits available and eligibility that applies at the time services are completed and a claim is submitted for payment.

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INSTRUCTIONS

A. WHEN TO USE THIS FORM

This claim form is to be used only when it has been necessary to purchase prescriptions because your participating pharmacy did not honor your identification card or was unable to directly submit your claim. It should also be used when it was necessary to have your prescriptions filled at a non-participating pharmacy.

Submit this form to the address below as soon as you have your prescription(s) filled in order to receive prompt payment. IT IS NOT necessary to keep the form until completely filled.

B. HOW TO COMPLETE THIS FORM

1. Complete the upper portion of the claim form under **Cardholder Information.** Transfer the Cardholder Identification Number, Member Number (if applicable) and Group Number from your identification card.

2. A separate claim form must be completed for each **patient.**

3. Have your pharmacist complete the **PRESCRIPTION INFORMATION** section for each prescription filled and the **PHARMACY INFORMATION** section. If you are unable to have the form completed by your pharmacist, most of the information needed in these sections can be copied from the prescription label and/or your receipt.

   IMPORTANT: The drug quantity, drug name and strength **or** eleven digit National Drug Code (NDC) is required and **must** appear on your submitted claim(s) or receipt(s).

4. **The original paid pharmacy receipt(s) must accompany this form. A cash register receipt is not satisfactory proof of purchase.**

5. **FOR COMPOUNDED PRESCRIPTIONS ONLY:** If your pharmacist tells you this is a compounded prescription, you must complete CLAIM NUMBER 6. Ask your pharmacist for assistance. The NDC number appearing on the claim should be that of the most expensive prescription ingredient. Should you have more than one compounded prescription, please use additional claim forms.

6. Claim forms submitted without the required information can cause payment delays and result in the information being returned for completion.

C. WHERE TO MAIL THIS FORM

1. Mail this form and your original paid pharmacy receipt(s) to: Your Benefit Manager at your company or:

   Envision/Rx Options, Inc.
   2181 East Aurora Road
   Suite 201
   Twinsburg, Ohio 44087

2. Please allow up to eight weeks for processing and payment of your claims.

3. You may call 1-800-361-4542 between 8:00 AM and 9:00 PM (Eastern Time) for questions or problems concerning your submitted claims.

CLAIMS WITH MISSING OR ILLEGIBLE INFORMATION WILL BE RETURNED!