BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Dental Expense Claim

Regular Dental Program
P O Box 830389
Birmingham, AL 35283-0389

TO BE COMPLETED BY SUBSCRIBER

1. Patient Name
2. Relationship to Employee: Self ☐ Spouse ☐ Child ☐ Other ☐
3. Sex: Male ☐ Female ☐
4. Patient Birthdate: Month | Day | Year
5. If Full Time Student Give School Name and City
6. Employee/Subscriber Name (Last Name, First Name, M.I.)
7. Contract Number
8. Employee/Subscriber Mailing Address
9. Employer (Company) Name and Address
City, State, Zip
City, State, Zip
10. Group Number
11. Division Number
12. Is patient covered by another dental plan? No ☐ Yes ☐ If yes, complete the following: Name of Policy Holder; Policy or Contract No.
Dental Plan Name
Group Number
Name and Address of Carrier
13. I have reviewed the following treatment plan. I authorize release of any information relating to this claim.
Signed (Patient, or Parent, if Minor)
Date
Pay Subscriber ☐ Pay Dentist ☐

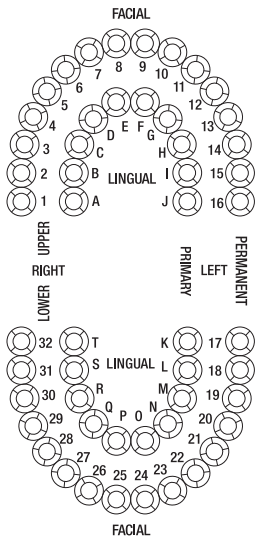
TO BE COMPLETED BY DENTIST

14. Dentist Name
15. Mailing Address
City, State, Zip
16. Dentist So. Sec. or T.I.N.
17. Dentist Phone Number
18. Plan Code/Provider Number
19. Radiographs or models enclosed? No ☐ Yes ☐ How many? ☐
20. ☐ Actual Services ☐ Predetermination

	No	Yes	If yes, enter brief description and dates.
21. Is treatment result of occupational illness or injury?	☐	☐	
22. Is treatment result of auto accident?	☐	☐	
Other accident?	☐	☐	
23. If prosthesis, is this initial placement?	☐	☐	If no, reason for replacement / Date of prior placement

25. Examination & Treatment Plan – List in order from Tooth #1 through Tooth #32 – Use Charting System Shown

Identify Missing Teeth With "X"



Tooth #, Letter or Quadrant	Surface	Description Of Service (Including X-Rays, Prophylaxis, Materials Used, Etc.) Line Number	Date Service Performed Month Day Year	Procedure Number	Fee	For Administrative Use Only
		1.				
		2.				
		3.				
		4.				
		5.				
		6.				
		7.				
		8.				
		9.				
		10.				

26. I hereby certify that the procedures as indicated by date have been completed.
Signed (Dentist or Legal Representative)
Date
TOTAL FEE CHARGED