

**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 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		3. Patient Sex Male Female <input type="checkbox"/> <input type="checkbox"/>		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 City, State, ZIP				9.		10. Employer (Company) Name									
10a. Employer (Company) Address				11.-14.											
15. <b>Coordination Of Benefits</b> Is patient covered under any other dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Insuring Co. _____ Policy # _____ Month Day Year Address _____ Effective Date of Coverage ____/____/____ Employer _____ Sex <input type="checkbox"/> Male <input type="checkbox"/> Female Birthdate ____/____/____ Insured _____ Relationship to Patient _____ <b>If The Other Insurance Is Primary, Attach The Other Company's Explanation Of Benefits.</b>						I Have Reviewed The Following Treatment Plan. I Authorize Release Of Any Information Relating To This Claim. <b>Make Payment To:</b> <input type="checkbox"/> Employee/Subscriber (Include Current Address) (Check One) <input type="checkbox"/> Dentist (Include Blue Cross and Blue Shield of Texas Provider Account No. To Receive Payment)									
16. Dentist Name			24. Is Treatment Result Of Occupational Illness Or Injury?		No Yes		If Yes, Enter Brief Description And Dates.								
17. Mailing Address City, State, ZIP			<b>Blue Cross and Blue Shield of Texas Provider Account No.</b>		25. Is Treatment Result of Auto Accident?		No Yes		27. Date of Accident ____/____/____						
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 Remaining 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 Date Appliances Placed Mos. Treatment Already Commenced,					
<b>Identify Missing Teeth With X</b> Enter 	31. Examination And Treatment Plan List In Order From Tooth No. 1 Through No. 32 Use Charting System Shown										For Office Use Only				
	Tooth # Or Letter	Surface	L I N E	Description of Service (Including X-Rays, Prophylaxis, Materials Used, Etc.)				Date Service Performed (Completed) Mo Day Year		Procedure Number		Fee			
32. Remarks For Unusual Services										Total Fee Charged					
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

- |         |   |  |
|---------|---|--|
| 1-4     | Patient's name, <u>birthdate</u> , <u>sex</u> and <u>relationship</u> of patient to employee.                           | Use patient's full name (NO NICKNAMES, please). All items <u>must</u> 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

- |         |   |  |
|---------|---|--|
| 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.