MEMBER DENTAL CLAIM FORM

BlueCross BlueShield Minnesota

United Concordia
Dental Claims Administrator
P.O. Box 69449
Harrisburg, PA 17106-9449

1. Type of Transaction (*Mark all applicable boxes*)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

3. Company/Plan Name, Address, City, State, Zip Code

Dental Claims Administrator - UCD
PO BOX 69449
Harrisburg PA 17106-9449

4. Dental? ☐ Medical? ☐ (if both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (*Last, First, Middle Initial, Suffix*)

6. Date of Birth (*MM/DD/CCYY*)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (*MM/DD/CCYY*)	14. Gender ☐ M ☐ F	15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number	17. Employer Name: Blue Cross Blue Shield Minnesota Medicare	

18. Relationship to Policyholder/Subscriber in #12 Above ☒ Self ☐ Spouse ☐ Dependent Child ☐ Other	19. Reserve For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (*MM/DD/CCYY*)	22. Gender ☐ M ☐ F	23. Patient ID/Account # (Assigned by Dentist)

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "**A**") A _____ B _____ C _____ D _____

31a. Other Fee(s)
32. Total Fee $ 0.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or 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 by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ____ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (*MM/DD/CCYY*)

42. Months of Treatment Remaining:
43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44)
44. Date of Prior Placement (*MM/DD/CCYY*)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI	50. License Number	51. SSN or TIN
52. Additional Provider ID	52a. Phone Number	

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI	55. License Number
56. Address, City, State, Zip Code	56a. Provider Specialty Code
57. Phone Number	58. Additional Provider ID

Instructions for Submitting Dental Member Claim Form

BlueCross BlueShield Minnesota

Blue Cross Medicare Plans

Instructions for Submitting Member
Dental Claim Form

Members who have dental benefits through their Blue Cross and Blue Shield of Minnesota ("Blue Cross") Medicare plan can submit a Member Dental Claim Form to request reimbursement of non-medical dental services received from a dentist outside of Blue Cross' Medicare Dental network when the provider does not submit the claim. Please follow the steps below to submit the claim.

Complete a separate Member Dental Claim Form for each patient and provider. Claims must be submitted within one year from the date of service.

Members submitting their own dental claim:

- Item 1: Check "statement of actual services" for reimbursement of completed dental services.
- Item 2: If applicable, provide predetermination number.
- Items 4-11: Only complete if you have additional dental insurance coverage. If you do not have additional dental insurance, leave these items blank.
- Items 12-16: Provide your policy information. Subscriber ID and plan/group number can be found on the front of your Blue Cross Medicare health plan ID card.
- Items 19-23: Not applicable to Medicare patients. You may leave these items blank.
- Items 24-35: Your dentist will need to complete these items. If your dentist does not agree to complete these items, you may attach a copy of your itemized bill from the dental provider with the dentist's name, address, and phone number.
- Item 36: Read patient consent statement, sign, and date.
- Item 37: You will designate who payment should be sent to. **If you wish for the payment to be made directly to you, write "FEE PAID" on the line instead of signing it and provide proof of payment** (e.g., receipt from provider office). If you wish for the payment to be sent directly to your dentist, please sign your name and date the statement**.**
- Items 38-58: Your dentist will need to complete these items. If your dentist does not agree to complete items 38-58, you may attach a copy of your itemized bill from the dental provider with the dentist's name, address, and phone number.

Dental providers submitting claim on behalf of their patient:

For dental providers completing and submitting the claim form on behalf of their patient, please complete the following sections:

- Dental office will need to fill out items 1-35, and 38-58.
- Please designate who payment should be sent to in item 37. **If you wish for the payment to be made directly to the patient/member, write "FEE PAID" on the line in item 37 instead of signing it and provide itemized bill or billing statement.** If you wish for the payment to be sent directly to the dental office, please sign and date item 37**.**

Submitting your claim form:

1. Attach completed claim form
2. Attach a copy of the itemized bill, which should include:
    - The provider's name, address, and phone number
    - The date and type of service
    - The charge for each service
3. Mail completed dental claim form along with a copy of the itemized bill within one year from the date of service to:

    Dental Claims Administrator – UCD
    PO Box 69449
    Harrisburg, PA 17106-9499

If you have further questions or need assistance with filling out the form, please call Dental Customer Service toll-free at the number on the back of your card (TTY users should call 711) Monday through Friday 8 a.m. to 8 p.m. Central Time.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.

CA: For your protection California law requires that the following appear on the form: Any person who knowingly presents a false claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

DC & RI: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FL: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.

IN & OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

KY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

LA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

VA: Any person who within the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

TN & WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

AZ: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.