

South Carolina

*BlueCross BlueShield of South Carolina
is an independent licensee of the
Blue Cross and Blue Shield Association*

☐ Major Medical ☐ FEP Dental Insurance
☐ Dental Insurance

PART I – TO BE COMPLETED BY EMPLOYEE							3. Sex M F		4. Patient Birthdate Mo. Day Year			5. If full-time student: School City	
1. PATIENT NAME First Initial Last				2. Relationship to Employee Self Spouse Child Other									
6. Employee/Subscriber Name First Middle Last							7. Employee Social Security No./Contract No.						
8. Employee/Subscriber Mailing Address							9. Employer (Company) Name and Address						
City			State		ZIP		11. Do you or your spouse have any other dental insurance? ☐ Yes ☐ No If yes, please answer the following questions: Policyholder's Name: SSN or ID No.: Name and Address of Policyholder's Employer:						
10. I hereby authorize release of any information relative to this claim to the insurer and direct that benefits be made payable to: ☐ Dentist ☐ Myself													
Date		Employee or Spouse Signature											

12. Is treatment result of occupational illness or injury?	No	Yes	If YES, enter brief description and dates		19. REMARKS FOR UNUSUAL SERVICES	
13. Is treatment result of auto accident?						
14. Other accident?						
15. Are any services covered by another plan or Medicare B?						
16. If prosthesis, is this initial placement?			(If NO, Reason for Replacement)	17. Date of Prior Placement		
18. Is treatment for orthodontics?			If services already commenced: Enter	Date of case diagnosis	X-rays submitted ☐ Yes ☐ No	
Date Appliances Placed			Mos. Treatment Remaining			Ir. Indicate Missing Teeth With An "X"

20. EXAMINATION AND TREATMENT PLAN. LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32.															
A Tooth No. or Letter	B Surface	C Date of Service	D Place of Service *	E		Description of Services (Including X-rays, prophylaxis, materials used, etc.)	F Diagnosis Code	G Charges	H (For Administrative Use Only)						
				Procedure Code	Modifiers				Type Service	Days Units	MP SPI	AC Code	Disp	RB LF	
21. Signature of Dentist <i>(I certify that the statements on the reverse apply to this bill and are made a part hereof.)</i>						26. Accept Assignment <i>(See back)</i>		23. Total Charge		24. Amount Paid		25. Balance Due			
						Yes ☐ No ☐									
Signed _____ Date _____						27. Your Social Security No.		29. Physician's or Supplier's Name, Address, Zip Code and Telephone No.							
						28. Your Employer I.D. No.									
22. Your Patient's Account No.								I.D. No.							

CLAIM FORM INSTRUCTIONS

PLEASE BE SURE TO CHECK THE APPROPRIATE BLOCK ON THE FRONT OF THE CLAIM FORM (I.E. DENTAL INSURANCE, MAJOR MEDICAL, OR FEP DENTAL INSURANCE).

ITEMS 1-11 – MEMBER INFORMATION

The patient provides information on Items 1-11 in order for the coverage to be identified. (Note: *All* items must be completed before we can process your claim.)

ITEMS 12-29 – DENTIST INFORMATION

Please complete Items 12-29.

SIGNATURE ITEM 21:

I certify that I personally performed the described services or they were performed by my employee under my immediate personal supervision.

ASSIGNMENT ITEM 26:

When I mark Item 26 “Yes” and properly complete this claim form, I understand that any covered benefit payment will be made directly to me.

When I mark Item 26 “No” or fail to mark it either “Yes” or “No,” I further understand that any covered benefit payment will be made directly to the insured subscriber.

ITEM 27:

Complete this item if filing under a corporation name.

A pre-determination of benefits can be made only when such charges for the course of treatment to be performed will exceed \$100.00. For such cases, please complete all items on the claim form except Item No. 20C (date(s) of service) indicating the treatment plan and the estimated charges and mail to the address below. A pre-determination form will be returned to you indicating the allowable amount. This amount is always subject to the deductible and coinsurance provisions of the contract. Upon completion of the services indicated on the treatment plan, enter the date(s) the services were performed and submit the pre-determination form for payment of benefits. NOTE: There is no preauthorization of benefits for the FEP Dental Insurance program.

MAIL FEP DENTAL CLAIM FORMS TO:

**BlueCross BlueShield of South Carolina
1180 Sam Rittenberg Blvd., Suite 100
Charleston, South Carolina 29407-3383**

Phone Number: 1-800-444-4325

MAIL ALL OTHER DENTAL CLAIM FORMS TO:

**BlueCross BlueShield of South Carolina
Dental Claims Department
P.O. Box 100300
Columbia, South Carolina 29202-3300**