



**BlueCross BlueShield  
of Alabama**

# Dental Expense Claim

Regular Dental Program  
P.O. Box 830389  
Birmingham, Alabama 35283-0389  
(205) 988-2213

An Independent Licensee of the Blue Cross and Blue Shield Association.

## TO BE COMPLETED BY SUBSCRIBER

1. Patient Name		2. Relationship to Employee Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				3. Sex M <input type="checkbox"/> F <input type="checkbox"/>		4. Patient Birthdate Month Day Year MM DD YYYY			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 City, State, Zip						9. Employer (Company) Name and Address City, State, Zip						
10. Group Number		11. Division Number		12. Is patient covered by another dental plan? <input type="checkbox"/> No <input type="checkbox"/> Yes: If yes, complete the following:		Name of Policy Holder			Policy or Contract No.			
Dental Plan Name		Group No.		Name and Address of Carrier								
13. I have reviewed the following treatment plan. I authorize release of any information relating to this claim.										Pay Subscriber <input type="checkbox"/>		
Signed (Patient, or Parent, if Minor)										Date		
										Pay Dentist <input type="checkbox"/>		

## TO BE COMPLETED BY DENTIST

14. Dentist Name				21. Is treatment result of occupational illness or injury? No <input type="checkbox"/> Yes <input type="checkbox"/>		If yes, enter brief description and dates.					
15. Mailing Address City, State, Zip				22. Is treatment result of auto accident? <input type="checkbox"/>							
				Other accident? <input type="checkbox"/>							
				23. If prosthesis, is this initial placement? <input type="checkbox"/>		24. Date of prior placement					
16. Dentist So. Sec. or T.I.N.		17. Dentist Phone No.		18. Plan Code/Provider Number		19. Radiographs or models enclosed? (How many?) No <input type="checkbox"/> Yes <input type="checkbox"/>					
						20. Actual Services Predetermination <input type="checkbox"/>					
Identify Missing Teeth With "X"  		25. Examination & Treatment Plan – List in order from Tooth #1 through Tooth #32 – Use Charting System Shown						<b>For Administrative Use Only</b>			
		Tooth #, Letter or Quadrant	Surface	Description Of Service (Including X-Rays, Prophylaxis, Materials Used, Etc.) Line No.	Date Service Performed					Procedure Number	Fee
				1	Mo.	Day	Yr.				
				2	MM	DD	YYYY				
				3	MM	DD	YYYY				
				4	MM	DD	YYYY				
				5	MM	DD	YYYY				
				6	MM	DD	YYYY				
				7	MM	DD	YYYY				
				8	MM	DD	YYYY				
				9	MM	DD	YYYY				
		10	MM	DD	YYYY						

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