Patrius Health

DENTAL EXPENSE CLAIM

FILL OUT A SEPARATE FORM FOR EACH PATIENT.
Use this form to file a claim for any eligible dental expenses.
Please **print** clearly with black ink or **type**.

1. Patient's Name (only one Patient per form)

Last Name	First Name	Middle Name
Street Address		

City	State	Zip	Daytime Telephone

2. Member ID as shown on your I.D. Card
(include any letters, if applicable)

3. Patient's Date of Birth

4. Patient's Gender ☐ **Male** ☐ **Female**

5. Is patient covered under any other group dental insurance plan? (including any other Blue Cross and Blue Shield coverage).

☐ **YES** ☐ **NO** If yes, complete the following:

Name of Policy Holder

Last Name	First Name	Middle Name
Name and Address of Insuring Company		

I.D. Number	Policy Effective Date	

6. Was condition related to:

A. Patient's Employment	☐ **YES**	☐ **NO**
B. Auto Accident	☐ **YES**	☐ **NO**
C. Other Accident/Injury	☐ **YES**	☐ **NO**

(If **yes**,give date of accident or onset of illness):

7. Diagnoses (type of illness or injury)

8. Select One: ☐ **Pay Member** ☐ **Pay Provider**

INSTRUCTIONS: Attach the original bill or statement from the physician or supplier and **keep a copy for your records**.
Make sure the bill contains all required information (see back of form for required information). Sign this form.

I, the undersigned, furnished the above information to enable to consider this claim for payment, and I certify that such information is true and correct and that the expenses were incurred by the above named patient.

Signature	Date Signed

DENTAL EXPENSE CLAIM

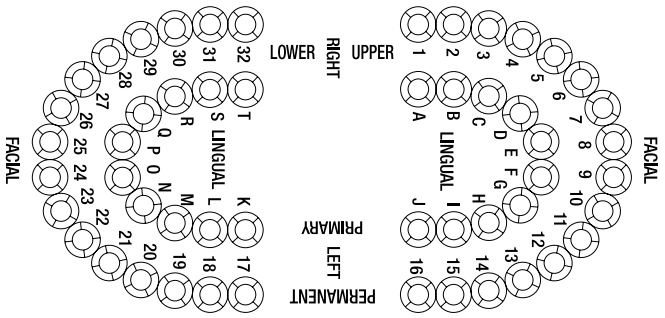
9. Dentist or Provider

Last Name	First Name		
Street Address			
City	State	Zip	Phone
Dentist SSN or TIN	Dentist NPI		

10. Examination and Treatment Plan

- **List in order from Tooth #1 through Tooth #32**
- **Use Charting System Shown**

Identify Missing Teeth with "X"



Tooth #, Letter, or Quadrant (If applicable)	Surface (If applicable)	Description of Service	Date of Service (M M D D Y Y Y Y)	Procedure Number	Fee
		1.			
		2.			
		3.			
		4.			
		5.			
		6.			
		7.			
		8.			
		9.			
		10.			
Comments:				Total Fee Charged	

11. I hereby certify that the procedures as indicated by date have been completed.

Signature	Date Signed

Signed (Dentist or Legal Representative)

SEE EASY CLAIM FILING INSTRUCTIONS

FILING YOUR CLAIM IS EASY

1. Fill out the Dental Expense Claim form (include all requested information).
2. Attach the bill (or clear copy of the bill) to this form.

Your bill should include the following information: (do not attach a balance forward bill)

- Patient's full name.
- Date of treatment.
- A description of the treatment provided (i.e. oral exam, extraction, dentures, etc.)
- A diagnosis (If Applicable).
- Charge for each treatment.
- Place of treatment (i.e. dentist's office, hospital, one day surgery clinic, etc.)
- Date of accident (if applicable).

Note: The above information is usually provided on an itemized bill from the provider.)

Members can mail the completed form to:

Patrius Health
Attention: Dental Claims
450 Riverchase Parkway East
Birmingham, AL 35244

Blue Advantage (PPO) is a PPO plan with a Medicare contract.
Enrollment in Blue Advantage (PPO) depends on contract renewal.

Patrius Health

Patrius Health is an independent licensee of the Blue Cross and Blue Shield Association.