BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Dental Expense Claim

Regular Dental Program
P O Box 830389
Birmingham, AL 35283-0389

TO BE COMPLETED BY SUBSCRIBER

1. Patient Name

2. Relationship to Employee — Self ☐ Spouse ☐ Child ☐ Other ☐

3. Sex — Male ☐ Female ☐

4. Patient Birthdate — Month | Day | Year

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? No ☐ Yes ☐ If yes, complete the following:

Name of Policy Holder

Policy or Contract No.

Dental Plan Name

Group Number

Name and Address of Carrier

13. I have reviewed the following treatment plan. I authorize release of any information relating to this claim.

Signed (Patient, or Parent, if Minor)

Date

Pay Subscriber ☐ Pay Dentist ☐

TO BE COMPLETED BY DENTIST

14. Dentist Name

15. Mailing Address

City, State, Zip

16. Dentist So. Sec. or T.I.N.

17. Dentist Phone Number

18. Plan Code/Provider Number

19. Radiographs or models enclosed? No ☐ Yes ☐ How many? ☐

21. Is treatment result of occupational illness or injury? No ☐ Yes ☐ If yes, enter brief description and dates.

22. Is treatment result of auto accident? No ☐ Yes ☐

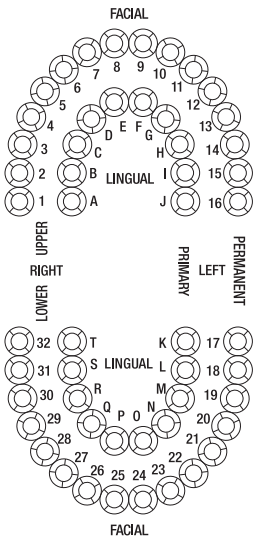
Other accident? No ☐ Yes ☐

23. If prosthesis, is this initial placement? No ☐ Yes ☐ If no, reason for replacement — Date of prior placement

24. ☐ Actual Services ☐ Predetermination

25. Examination & Treatment Plan – List in order from Tooth #1 through Tooth #32 – Use Charting System Shown

Identify Missing Teeth With "X"



Tooth #, Letter or Quadrant	Surface	Description Of Service (Including X-Rays, Prophylaxis, Materials Used, Etc.) Line Number	Date Service Performed Month Day Year	Procedure Number	Fee	For Administrative Use Only
		1.				
		2.				
		3.				
		4.				
		5.				
		6.				
		7.				
		8.				
		9.				
		10.				

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

Signed (Dentist or Legal Representative)

Date

TOTAL FEE CHARGED

CL-265 (Rev. 9-2009)