DENTAL CLAIM FORM
Blue Shield of California

Submit Dental Claims To: Blue Shield, P.O. Box 30605 Salt Lake City, UT 84130-0605

Question? Call: 1 (877) 403-2273, Monday through Friday, 5 a.m. to 8 p.m., PT

Blue Shield Use Only	**IMPORTANT: Treatment plans exceeding $1,200.00 should be submitted for precertification. Failure to do so may result in patient responsibility for claims subsequently adjusted or denied.**

Patient/participant information

1. Patient Name	2. Relationship To Employee (Self / Spouse/Domestic Partner / Child / Other)	3. Sex (M / F)	4. Patient Birthdate (Month / Day / Year)	5. If Full Time Student (School / City)

6. Employee/ Subscriber Name	First / Initial / Last	7. Employee/participant No. (see dental ID card)
8. Mailing Address, Street, City, State, Zip Code		9. Group Name: County of Orange
10. Is patient covered by another dental plan?	Dental Plan Name / Union Local / Policy No. / Name and Address of Carrier	

Dentist information ☐ Dentist's pretreatment estimate ☐ Dentist's statement of actual services

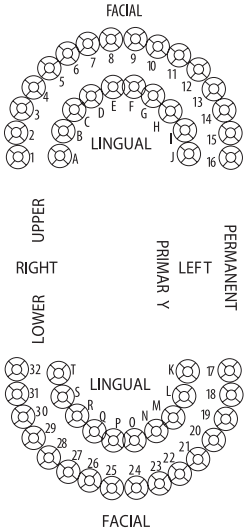
11. Dentist SS# or T.I.N.	12. Dentist license no.	13. Dentist phone no.	14. Dentist's name, address, city, state, Zip Code
15. Provider ID			

16. First visit date of current series	17. Place of treatment (Office / Hospital / ECF / Other)	18. Radiographs or models enclosed? (Yes / No / How many?)	22. If Prosthesis/ crown is this initial placement? (Yes / No)	If No, the reason for replacement	23. Date of prior placement

19. Is treatment result of occupation illness or injury? (Yes / No)	If yes, enter brief description and dates	24. Is treatment for orthodontics? (Yes / No)	If services already commenced enter: Date appliances placed / Months of treatment remaining
20. Is treatment result of auto accident? (Yes / No)		I hereby certify that the services listed have been or will be provided by me. Dentist's Signature / Date	
21. Other accident? (Yes / No)			

25. Examination and treatment plan — List in order from tooth no. 1 Through tooth no. 32

Identify missing teeth with "X"



Tooth No. or letter	Surface	Description of Service (Including x-rays, prophylaxis, materials used etc.)	Date Service Performed MO	DAY	YEAR	ADA Procedure Number	Fee	Blue Shield use only Allowed Amount
						Total Fee Actually Charged		
		Remarks:						

26. Patients Authorization: I have been informed of the treatement plan and associated fees identified above, and, to the extent permitted by law, I authorize the release of information relative to this course of treatment and to the payment activities in connection with this claim.

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. I understand that I am responsible for the charges for any service not approved by benefit pre-certification review, or are rendered during any ineligible period and for the copayments, deductibles and amounts exceeding the calendar year maximum of my dental plan. I understand that I may request a copy of any precertification review determination from Blue Shield.

Signed (Patient or Guardian if Minor) Date

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

Participant/Member Signature Date