

CLAIM FORM INSTRUCTIONS

PLEASE BE SURE TO CHECK THE APPROPRIATE BLOCK ON THE FRONT OF THE CLAIM FORM (I.E. BLUE SHIELD – ORAL SURGERY, 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 ALL DENTAL CLAIM FORMS TO:

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