Dental Claim Form

Bronxville Public School Employees' Benefit Trust

Mail To: Anthem Dental Claims,
P.O. Box 659444,
San Antonio, TX 78265-9444

Header Information

1. **Type of Transaction** (check one)
   - ☐ Statement of Actual Services
   - **-OR-**
   - ☐ Request for Predetermination/Preauthorization
2. **Predetermination/Preauthorization Number**

Primary Payer Information

Anthem Dental Claims – Payor ID: 84105
P.O. Box 659444, San Antonio, TX 78265-9444

Primary Member Information

11. **Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code**

12. **Date of Birth** (MM/DD/YYYY)

14. **Gender** ☐ M ☐ F ☐ NB

15. **Member ID#**

16. **Employer Name:** Bronxville Public School Employees' Benefit Trust

Other Coverage

3. **Other Dental Coverage?** ☐ No (Skip #4-9) ☐ Yes (fill below)
4. **Subscriber Name (Last, First, Middle Initial, Suffix)**
5. **Date of Birth** (MM/DD/YYYY)
6. **Gender** ☐ M ☐ F ☐ NB
7. **Subscriber ID#**
8. **Plan/Group #**
9. **Relationship to Primary Member**
10. **Other Carrier Name, Address, City, State, Zip**

Patient Information *(if other than Primary)*

18. **Relationship to Primary** (Check one) ☐ Spouse ☐ Dependent Child ☐ Other _____
19. **Student Status** ☐ FTS ☐ PTS
20. **Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code**
21. **Date of Birth** (MM/DD/YYYY)
22. **Gender** ☐ M ☐ F ☐ NB
23. **Patient ID /Account #**

Record of Services Provided

	Procedure Date (MM/DD/YYYY)	Area of Oral Activity	Tooth System	Tooth Number(s) or Letter(s)	Tooth Surface	Procedure Code	Description	Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

Missing Teeth Information

Place an "X" on each missing tooth

Permanent															
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25								
24	23	22	21	20	19	18	17								

Primary									
A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

Other Fees

Total Fee

Remarks:

Authorizations

I have been informed of the treatment plan and associated fees. 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. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____ _____
Patient/Guardian Signature **Date**

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

X_____ _____
Patient/Guardian Signature **Date**

Billing Dentist or Dental Entity

(Leave blank if dentist or dental entity is not submitting claim on behalf of the patient)

Name, Address, City, State, Zip Code

Provider ID	SSN or TIN
License #	Phone #

Ancillary Claim / Treatment Information

Place of Treatment (check)
- ☐ Provider's Office
- ☐ Hospital
- ☐ ECF
- ☐ Other: _____

Number of Enclosures (00 to 99)
_____ Radiograph(s)
_____ Oral Image(s)
_____ Model(s)

Is treatment for Orthodontics?
- ☐ **No** (skip Ortho questions)
- ☐ **Yes** (complete all)

Ortho: Date Appliance Placed (MM/DD/YYYY)

Ortho: Months remaining of treatment: _____

Replacement of Prosthesis?
- ☐ **No**
- ☐ **Yes**
- ✓ **If Yes: Date Prior Placement:**

Treatment Resulting from: (check if applicable)
☐ Occupational illness/injury ☐ Auto accident ☐ Other Accident

Date of Accident: **Auto Accident State:**

Treating Dentist and Treatment Location Information

I hereby certify that the procedures as indicated by date are in progress for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X_____ _____
Signed (Treating Dentist) **Date**

Provider ID	License #
Phone # and Address:	