Wellmark BlueCross BlueShield of Iowa
An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 9354 • Des Moines, IA 50306-9354

ATTENDING DENTIST'S STATEMENT

BlueDental℠

Farm Bureau Call: (515) 558-7755 or (877) 202-0395; Federal Employees Call (515) 245-4784 or (800) 532-1537;
All other Blue Dental Call: (515) 558-7778 or (877) 333-0164

Check one:
☐ **Dentist's pre-treatment estimate**
☐ **Dentist's statement of actual services**

Carrier name and address

PATIENT COVERAGE INFORMATION

1. Patient name — first / middle initial / last
2. Relationship to employee — ☐ self ☐ child ☐ spouse ☐ other _____
3. Sex — m / f
4. Patient birthdate — mm / dd / yyyy
5. If full time student, school name: — city
6. Employee/Policyholder name and mailing address
7. Employee/Policyholder social security # or ID#
8. Employee/Policyholder birthdate — MM / DD / YYYY
9. Employer (company) name and address
10. Group Number
11. Is patient covered by another dental plan? ☐ Yes ☐ No — If yes, complete 12-a. — Is patient covered by a medical plan? ☐ Yes ☐ No
12-a. Name and address of carrier(s)
12-b. Group number(s)
13. Name and address of other employer(s)
14-a. Employee/Policyholder name (if different than patient's)
14-b. Employee/Policyholder social security # or ID#
14-c. Employee/Policyholder birthdate — mm / dd / yyyy
15. Relationship to patient — ☐ self ☐ child ☐ spouse ☐ other _____

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

Signature (Patient or parent if minor) _____ Date _____/_____/_____

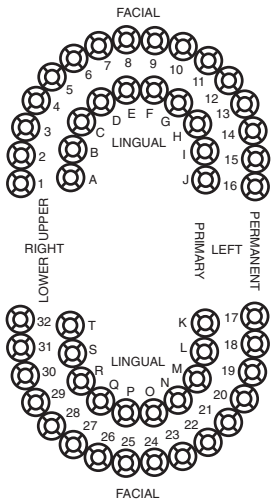
I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

Signature (Policyholder) _____ Date _____/_____/_____

BILLING DENTIST

16. Name of Billing Dentist or Dental Entity
17. Street Address where payment should be remitted
City, State, Zip Code
18. Dentist Social Security or T.I.N.
19. Licence #
20. NPI number
21. Phone number
22. Place of treatment — Office / Hosp. / ECF / Other
23. Radiographs or models enclosed — No / Yes / How many?
24. Is treatment result of occupational illness or injury? — No / Yes — If yes, enter brief description and dates
25. Is treatment result of auto accident? — No / Yes
26. Other accident? — No / Yes
27. If prosthesis, is this initial placement? — No / Yes — If no, reason for replacement
28. Date of prior placement ___/___
29. Is treatment for orthodontics? — No / Yes — If services already commenced, enter: Date appliances placed: / Months treatment remaining:

Identify missing teeth with "x"



30. Examination and treatment plan - List in order from tooth no. 1 through 32 - Use charting system shown.

Tooth # or letter	Surface	Description of Service (including x-rays, prophylaxis, materials used, etc.?	Date Service Performed Mo.	Day	Year	Procedure Number	Fee

For Administrative Use Only

31. Remarks for unusual services

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

Signature (Treating Dentist) _____ License Number _____ Date _____/_____/_____

NPI Number _____

Total Fee Charged

Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

In accordance with 0512

C-0365 3/07