



An independent licensee of the Blue Cross and Blue Shield Association

4000 House Avenue \*\* P O Box 2266  
Cheyenne, WY 82003-2266

# DENTAL CLAIM FORM

(Instructions for filing on second page)

PARTICIPANT'S NAME (Last, First, M.I.)		MEMBER ID NUMBER	
HOME ADDRESS (Street, City, State, Zip)			IS THIS A NEW ADDRESS? <input type="checkbox"/> Yes <input type="checkbox"/> No
PATIENT'S NAME (Last, First, M.I.)	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH (MM/DD/YYYY)	RELATIONSHIP TO PARTICIPANT <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child

DESCRIBE THE ILLNESS, INJURY OR SYMPTOMS REQUIRING TREATMENT:

IF ILLNESS OR INJURY RESULTED FROM AN ACCIDENT, WAS IT DUE TO: AUTO <input type="checkbox"/> EMPLOYMENT <input type="checkbox"/> OTHER <input type="checkbox"/> (Briefly Describe) _____	INDICATE DATE OF ACCIDENT (MM/DD/YYYY)
---	--

OTHER HEALTH INSURANCE:  
Is the patient covered by additional health insurance through an employer, a group such as a professional organization or any other group health insurance, including other Blue Cross and/or Blue Shield coverage?  YES  NO  
If yes, please complete this section.

NAME AND ADDRESS OF INSURING COMPANY (Street, City, State, Zip)	EFFECTIVE DATE (MM/DD/YYYY)	TERMINATION DATE (MM/DD/YYYY)
NAME OF POLICYHOLDER (Last, First, M.I.)	DATE OF BIRTH (MM/DD/YYYY)	IDENTIFICATION NUMBER (Including all letters & numbers)

**I CERTIFY THAT THE ABOVE IS CORRECT AND COMPLETE AND THAT I AM CLAIMING BENEFITS ONLY FOR THE CHARGES INCURRED BY THE PATIENT NAMED ABOVE.**

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

## INSTRUCTIONS FOR FILING CLAIMS

1. A separate claim form must be submitted for each family member.
2. Itemized bills for covered services, supplies and durable medical equipment **MUST** be attached and show:
  - A. Name of patient and date of birth
  - B. Date of service and charge for each
  - C. Type of services/supplies/equipment received (surgery, office calls, etc.)
  - D. Description of illness or accident
  - E. Date of accident
3. Bills for prescription medication must include above information as well as:
  - A. Patient's Name
  - B. Description of Illness or Accident
  - C. Name of Drug
  - D. Name of Pharmacy
  - E. Prescribing Physician
  - F. Date Purchased and Charge for Each Drug
  - G. If actual drug receipt is not available, pharmacist signature is required
4. Questions on filing dental claims should be directed to:

**Member Services Center**  
**Blue Cross Blue Shield of Wyoming**  
P O Box 2266  
Cheyenne, WY 82003-2266  
307.634.1393  
1.800.442.2376

**NOTE:** *Balance due statements, cash register receipts, cancelled checks and cash receipts are not acceptable.*

**ITEMIZED BILLS CANNOT BE RETURNED**

**SAMPLE OF BCBS IDENTIFICATION CARD**

