V	E	VI	BI	=R	D	E	I	AL	CI	LA	IM	F	JR	M								2	14/	V			10	Please su		
Н	EAL	ADER INFORMATION Type of Transaction (Mark all applicable boxes)																\$	W	T	M		NG	Dent P.O. B						
1.	Тур	e of	Tra	nsac	tior	ı (Ma	ırk a	II app	licabi	le bo	xes)										®	®						Harrisburg,		
				nent			al Se	rvices	s \square] Re	ques	t for l	Pred	eterm	ninat	ion/P	reautho	orizatio	on		An indepen	dent license	ee of the Blue	Cross and	Blue Shield	l Associa	tion			
2.	Pre				_		utho	orizati	on N	umb	er																	ance Company		
																				12.	Policyholder	/Subscri	ber Name	(Last, F	irst, Mic	ldle In	itial, Suffix), Address, City,	State	, Zip Code
ΙΝ	SU	RA	NC	E C	OMI	PAN	Υ/[DENT	ALE	BEN	EFIT	PLA	NII	VFOR	RMA	TIOI	V													
								ess, C									_													
																		13.	13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscriber ID (SSN or									SN or ID#)		
	OTHER COVERAGE (Mark applicable box and complete 5-11. If none, leave blank.)																						м							
0	THE	R	:01	/ER	AG	E (M	ark	appli	cable	bo	c and	com	plete	5-11	l. If r	one,	leave b	lank.)		16.	Plan/Group	Number		17. Er	nployer	Name	•			
_	Der					Med											l only.)													
5.	Nar	ne c	of Po	olicy	holo	der/S	ubs	cribe	r in #	4 (La	st, Fir	st, Mi	iddle	Initia	I, Suf	fix)					PATIENT INFORMATION 18. Relationship to Policyholder/Subscriber in #12 Above 19. Reserve For Future Use									
6.	Dat	e of	Bir	th (/	1M/I	DD/C	CYY)	_	end	_	.	3. Po	licyho	older	/Sub	scriber	ID (SSN	l or ID#)	20	Name (Last,						Other	n Code		
									_												ivairie (Last,	i ii st, iviit	adic illida	i, Juiin,	, riddic.	33, City	, State, 21 ₁	Couc		
9.	Plar	ı/Gı	ou	o Nu	mbe	er			10.					٠.			amed ir													
																	ndent		Other											
11	. Ot	her	Ins	uran	ce C	Comp	oany	//Den	tal Be	enefi	it Plar	ı Nan	ne, A	ddres	ss, Ci	ty, St	ate, Zip	Code												
										21.	21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (A								igned	by Dentis										
																м 🔲	F			-										
RI	CO	RD	0	F SE	RV	ICES	PF	ROVII	DED																					
		24. I	Proc	edu	re D	ate		25. Area of Oral		6. oth	2	.7. To	oth I	Numb	oer(s)	28. To	ooth	29. Proc	edure	29a. Diag.	29b.			30	Desci	ription			31. Fee
		(N	IM/	DD/	CCY	Y)		Cavity				0	r Let	ter(s))		Surf	ace	Cod	le	Pointer	Qty.				DC3C	i i ption			31. 166
1																														
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3							+																							
4							+																						+	
5							-																							
Н																														
33	. Mi	ssin	ıg T	eeth	Info	orma	tion	(Plac	e an	"X" o	n eac	h mi	ssing	toot	h.)			34.	Diagnosis	Code	Code List Qualifier $(ICD-9 = B; ICD-10)$						= AB) 31a. Other Fee(s)			
	1	2	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 34a. Diagno.							Diagnos	is Cod	s Code(s) A C _							1 CC(3)											
	32	3	31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 (Primary dia						nary diag	nosis in " A ") B D					D			32. Total Fee												
35	. Re	ma	rks																										I	
A	JTH	Ю	₹IZ	ATI	NC:	S														ANC	ILLARY CL	AIM/TF	REATME	NT INF	ORMA	TION				
36																	e respor			38. P	lace of Treat	ment	(6	e.g. 11=	office; 2	2=O/F	Hospital)	39. Enclosure	s (Y c	or N)
																	, unless		ohibiting		(Use "Place	e of Serv	ice Codes	for Prof	essiona	l Claim	ıs")]	
	all	or a	por	tion	of su	uch c	harg	ges. To	the e	exten	t perr	nitted	d by l	aw, I c	conse	ent to	your use	e and d	isclosure	40. Is Treatment for Orthodontics?							41. Date	Appliance Place	d (MN	//DD/CCYY)
	of I	ny p	orot	ecte	d he	alth i	ntor	matio	n to c	arry	out p	ayme	nt ac	tivitie	es in c	conne	ction wi	th this	claim.	No (Skip 41-42) Yes (Complete 41-)				
Ι,	,																		İ			atment	43. Repla	acemen	t of Pros	thesis	44. Date	of Prior Placeme	nt (M	IM/DD/CCYY
l ′	Pat	ient	/Gı	ardi	an Si	ignat	ure										Date			R	emaining:		□ No	☐ Yes	(Compl	ete 44)				
37	The	reb	y aı	ıtho	ize a	and d	lirec	t payn	nent o	of the	e dent	tal be	nefit	s othe	erwise	e paya	able to n	ne, dire	ctly to	45. Tı	reatment Res	sulting fr			(F	,	1			
	the	bel	low	nam	ed d	lentis	st or	denta	l enti	ty.										Г	Occupation	anal illne	scc/injury		ito acció	dont	Otho	r accident		
																			ŀ											
)	(nscr	iher	Sign	atu	re											Date			40. D	ate of Accide	ent (wiwi	/DD/CCTT	,			47. Auto	Accident State		
RJ				_			DE	NTAL	EMP	TITY	مل) ا	we l	lank	if de	ntic	t or d	ental e	ntitui	s not	TRE	ATING DEA	ITIST A	ND TREA	ATMEA	ITLOC	ATIO	N INEQP	MATION		
								of the								e or u	ental e	marcy I	THOL		TREATING DENTIST AND TREATMENT LOCATION INFORMATION 53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require									
48	. Na	me	, Ac	dre	s, C	ity, S	tate	, Zip (Code												ultiple visits)				,		. 3	•		-
																				X						Date				
																			ł	54. NPI					5	55. License Number				
																			-			C+	- C - 1							
49	. NF	1						50. Lic	cense	Nu	mber			5	1. SS	N or 7	ΓIN			56. A	ddress, City,	state, Zi	p Code		5 S	6a. Prov pecialty	vider v Code			
52	Ac	diti	ona	al Pro	vid	er ID)					52a	Phor	ne Nu	ımhe	r				57. Pk	none Numbe	r			5	8 Ada	ditional Pro	ovider ID		