

# MEMBER CLAIM FORM

(please complete one form per provider)



## INSTRUCTIONS

1. You may need your dental provider to assist and supply information in completing this form, including the procedure code(s). Please also refer to the member claim form help sheet for additional information.
2. To request reimbursement for dental services provided, please submit the following to the address listed at the end of this form (any missing information may result in delay or denial of the request):
  - a. This completed and signed claim form.
  - b. Proof of services rendered.
  - c. Proof of payment for the services being requested for reimbursement.
3. Reimbursement will be sent to the member at the address Capital Blue Cross has on record. If you believe your address is different than the address of record, please call Member Services at **866.987.4213** (TTY: 711) for Capital Blue Cross Medicare Advantage PPO and **800.779.6962** (TTY: 711) for Capital Blue Cross Medicare Advantage HMO.
4. Retain a copy of all receipts and documentation for your records.

## MEMBER INFORMATION

Member ID #:	Date of Birth (MM/DD/YYYY):	
Last Name:	First Name:	Middle Initial:

## CLAIM INFORMATION

Dental Provider's Name:	Setting Where Treatment Was Received:	Phone Number:	Tax ID Number or National Provider Identifier (NPI):
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Address of Dental Provider:	Were services received outside of the U.S.? <input type="checkbox"/> No, proceed to the next section <input type="checkbox"/> Yes, answer the following questions: In what country was the patient seen? In what language was the bill written? In what currency was the bill paid?
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Date(s) of Service	Procedure Codes for Each Service Provided (if known)	Procedure Descriptions (e.g., office visit, dental cleaning, dental X-rays)	Tooth Number (if known)	Amount Paid
/ /				\$
/ /				\$
/ /				\$
/ /				\$
/ /				\$
/ /				\$
Total amount paid				\$

Attach another sheet if more services are reported.

Member or personal representative signature is required.

I attest that the above information is true and accurate and that the services were received and paid for in the amount requested as indicated above. I acknowledge that if any information on this form is misleading or fraudulent my coverage may be canceled and I may be subject to criminal and/or civil penalties for false healthcare claims. I also understand that Capital Blue Cross may request any additional information it deems necessary to verify that services were received and payment was made.

Printed Name	Signature	Date
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Please submit this form and all documentation to:

Dental Claims Processing Center  
PO Box 211424  
Eagan, MN 55121

# MEMBER CLAIM FORM HELP SHEET

FIELD NAME	DESCRIPTION
Member's ID #	Capital Blue Cross ID #, found on the front of the Capital Blue Cross ID card.
Member's Name	Last and first names and middle initial of member who received services.
Member's Date of Birth	Date of birth: MM/DD/YYYY
Provider's Name, Address, Telephone Number, Tax ID number, or National Provider Identifier (NPI)	A dental provider includes, but is not limited to, general dentist, periodontist, and oral surgeon.
In what setting did the patient receive treatment?	Most dental services are received in an office.
If services were rendered outside of the U.S.	If applicable, indicate in what country services were provided, in what language (if not English) the bill and proof of payment were written, and in what currency the bill was paid.
Date(s) of Service	The date(s) the services were provided to the patient.
Procedures, Services, or Supplies Provided	Provide a procedure code (if known) and detailed description (e.g., office visit, dental cleaning, dental X-ray).
Total Amount Paid	Total amount for which you are requesting reimbursement.
Proof of Service(s)	A document that demonstrates the service was actually rendered, listing date(s) of service, service(s) provided, and dollar amounts paid.
Proof of Payment	A document that demonstrates payment made by the member was received by the provider of service. Examples include: the front and back of the canceled check written to the provider or the bank encoded front of the check written to the provider; a credit card statement or receipt; a statement from the provider on the provider's letterhead with authorized signature indicating payment was made; a receipt for purchased items with the provider's name and address preprinted on the receipt with items listed and amount paid.

## PROOF OF SERVICE AND PROOF OF PAYMENT EXAMPLES

John Doe, DDS  
County Dental  
123 Any Street  
Anytown, PA 12345  
Telephone 555-555-7894  
Tax ID# XX-XXXXX

For Susan Sample

Date of Service 7/1/2020  
D0120 Periodic oral exam = \$50.00  
D0272 Bite wing x-rays - two = \$30.00

Total = \$80.00

PAID IN FULL

John Doe, DDS  
Lic# 1122334455

This example demonstrates both proof of payment and proof of service.

SUSAN SAMPLE  
10 MAIN STREET  
ANYTOWN, PA 12345

DATE 3/17/12

COUNTY DENTAL

PAID TO ORDER \$ 50.00

Fifty and 00/100

LOCAL BANK

001240

123456789 123456789 123456789 123456789

NATIONAL BANK 012345678  
4/18/2012  
1623306  
12345  
ABGGRD

ENCLOSURE

This example demonstrates proof of payment.