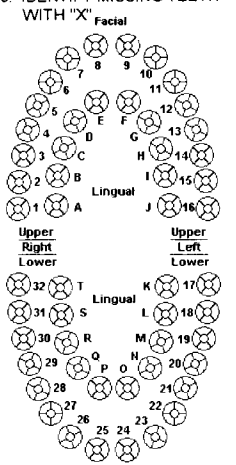


BLUE CROSS BLUE SHIELD OF MICHIGAN DENTAL CLAIM INQUIRY

1. <input type="checkbox"/> DENTIST'S PRE-TREATMENT ESTIMATE <input type="checkbox"/> DENTIST'S STATEMENT OF ACTUAL SERVICES PROVIDER ID # _____		2. <input type="checkbox"/> MEDICAID CLAIM <input type="checkbox"/> EPSDT PRIOR AUTHORIZATION # _____ PROVIDER ID # _____		3. MAIL TO: BLUE CROSS BLUE SHIELD OF MICHIGAN P.O. BOX 49 DETROIT, MICHIGAN 48231-0049						
PATIENT COVERAGE INFORMATION	4. PATIENT NAME FIRST _____ M.I. _____ LAST _____		5. RELATIONSHIP TO EMPLOYEE <input type="checkbox"/> SELF <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER _____		6. SEX M F		7. PATIENT BIRTHDATE MM DD YYYY		8. IF FULL TIME STUDENT SCHOOL _____ CITY _____	
	9. EMPLOYEE/SUBSCRIBER NAME AND MAILING ADDRESS _____			10. EMPLOYEE/SUBSCRIBER DENTAL PLAN ID # _____		11. EMPLOYEE/SUBSCRIBER BIRTHDATE MM DD YYYY		12. EMPLOYER (COMPANY) NAME AND ADDRESS _____		13. GROUP NUMBER _____
	14. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? IF YES, COMPLETE 15-A. <input type="checkbox"/> YES <input type="checkbox"/> NO		15 - A. NAME AND ADDRESS OF CARRIER(S) _____			15 - B. GROUP NO.(S) _____			16. NAME AND ADDRESS OF OTHER EMPLOYER(S) _____	
	17 - A. EMPLOYEE/SUBSCRIBER NAME (IF DIFFERENT FROM PATIENT'S) _____			17 - B. EMPLOYEE/SUBSCRIBER DENTAL PLAN ID # _____		17 - C. EMPLOYEE/SUBSCRIBER BIRTHDATE MM DD YYYY		18. RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER _____		
19. I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN AND FEES. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. _____ SIGNED (PATIENT) _____ DATE _____					20. I HEREBY AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THE BELOW NAMED PROVIDER. _____ SIGNED (EMPLOYEE/SUBSCRIBER) _____ DATE _____					
BILLING DENTIST	21. NAME OF BILLING DENTIST OR DENTAL ENTITY _____					REASON FOR INQUIRY _____				
	22. ADDRESS WHERE PAYMENT SHOULD BE REMITTED _____									
	24. DENTIST SOC. SEC. OR T.I.N. _____		25. DENTIST LICENSE NO. _____		26. DENTIST PHONE NO. _____					
	27. FIRST VISIT DATE CURRENT SERIES _____		28. PLACE OF TREATMENT OFFICE, HOSP, ECF, OTHER _____		29. RADIOGRAPHS OR MODELS ENCLOSED? NO YES HOW MANY? _____		30. ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> AUTO <input type="checkbox"/> OTHER _____			
36. IDENTIFY MISSING TEETH WITH "X" 		37. EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THRU TOOTH NO. 32 - USING CHART SYSTEM SHOWN								INTERNAL USE ONLY
INTERNAL USE ONLY		TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE	P.M.	SERVICE DATE MM DD YYYY	PROCEDURE NUMBER	FEE		
38. COMMENTS/ADDITIONAL INFORMATION _____										
39. I CERTIFY THE SERVICES HEREIN WERE PERFORMED PERSONALLY BY ME OR UNDER MY SUPERVISION, IN MY PRESENCE AND ARE SUBMITTED IN ACCORDANCE WITH THE PROVISIONS OF THE SUBSCRIBER'S CONTRACT. _____ SIGNED (TREATING DENTIST) _____ LICENSE NUMBER _____ DATE _____							41. TOTAL FEE CHARGED _____		42. PAYMENT BY OTHER PLAN _____	
40. INTERNAL USE ONLY							MAX ALLOWABLE _____			
							DEDUCTIBLE _____			
							CARRIER % _____			
							CARRIER PAYS _____			
							PATIENT PAYS _____			