



An Independent Licensee of the Blue Cross and Blue Shield Association.

DENTAL BENEFITS CLAIM FORM

P.O. Box 7728
Columbus, Georgia 31908-7728



UNIVERSITY SYSTEM OF GEORGIA DENTAL BENEFITS PLAN

CHECK ONE:
 C - For Payment
 P - For Precertification

EMPLOYEE/PATIENT INFORMATION	1. Patient's Name (First, Middle, and Last Name)		2. Relationship to Employee Self Spouse Child Other		3. Sex M F		4. Patient's Birthdate Mo. Day Yr.		5. Patient's Identification Number			
	6. Employee's Name First Middle Last			7. Employee's Group Number and/or Group Name USG0								
	8. Mailing Address Street City State Zip Code			9-10. If Full Time Student — School and City								
				11. Anticipated Graduation Date				12. Patient's Acct. #				
	13. Are Other Family Members Employed? Name/Soc. Sec. No.			14. Name and Address of Employer in Item 13				15. Is Patient Covered By Another Dental Plan? If None, so state.				
Name and Address of Plan		Policyholder's Name		Date of Birth		Identification No.		Group No.				
PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any Dental information necessary to process this claim and accept the following treatment Plan.)					I authorize payment of benefits to undersigned Dentist for services described below. NOTE: Benefits are not assignable to non-participating providers.							
Signature					Date		Employee's or Authorized Person's Signature					
DENTIST INFORMATION	16. Dentist's Name		24. Is Treatment Result of Occupational Illness or Injury? No Yes									
	17. Mailing Address Street City State Zip Code		25. Is Treatment Result of Auto Accident?		26. Other Accident?						27. Are Any Services Covered by Another Plan?	
	18. Dentist's IRS # or Soc. Sec. #		19. Dentist's License No.		20. Dentist's Phone No.		28. If Prosthesis or Crowns, is this Initial Placement?		If No, Reason For Replacement		29. Date of Prior Placement	
	21. First Visit Date Current Series	22. Place of Treatment Office Hosp. ECF Other		23. Radiographs or Models Enclosed? No Yes How Many?		30. Is Treatment for Orthodontics?		If Services Already Commenced Enter		Date Appliances Placed Mos. Treatment Remaining		
	DENTIST'S STATEMENT — I HEREBY CERTIFY THAT THE SERVICES LISTED HAVE BEEN OR WILL BE PROVIDED BY ME.					Dentist's Signature			Date			

31. EXAMINATION AND TREATMENT PLAN — LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 — USE CHARTING SYSTEM SHOWN BELOW.

SURFACES	Tooth # or Letter	Surface of Quadrant	DESCRIPTION OF SERVICE (Including X-rays, Prophylaxis, Materials Used, Etc.)	Date Service Performed			Procedure Number	Alt. Procedure Number	Fee										
				MO	DAY	YR													
B — Buccal																			
L — Lingual																			
M — Mesial																			
O — Occlusal																			
D — Distal																			
F — Facial/Labial																			
I — Incisal																			
QUADRANTS																			
1 — Teeth Nos. 1-8																			
2 — Teeth Nos. 9-16																			
3 — Teeth Nos. 17-24																			
4 — Teeth Nos. 25-32																			
Identify Missing Teeth With "X"																			
										TOTAL FEE CHARGED									
										Date Received		Adj Nbr	User Pend Codes				WC	Override Codes	
										Override Codes		DC	Adj/Rej	DLC	Adj Rea	WP	Ortho Pros	Date Ben Conf	