Blue Shield of California
An Independent Member of the Blue Shield Association

SUBMIT DENTAL CLAIMS TO:
BLUE SHIELD OF CALIFORNIA
P.O. BOX 272540
CHICO, CA 95927-2540

DENTAL SERVICE REPORT

BLUE SHIELD USE ONLY

IMPORTANT: **Treatment plans exceeding $250.00 should be submitted for precertification. Failure to do so may result in patient responsibility for claims subsequently adjusted or denied.**

SUBSCRIBER INFORMATION

1. PATIENT NAME	2. RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD OTHER	3. SEX M F	4. PATIENT BIRTHDATE MO. DAY YEAR	5. IF FULL TIME STUDENT SCHOOL CITY
6. EMPLOYEE/SUBSCRIBER NAME FIRST INITIAL LAST		7. EMPLOYEE/SUBSCRIBER SOCIAL SECURITY NO.		
8. MAILING ADDRESS, STREET, CITY, STATE, ZIP CODE		9-12. EMPLOYEE/SUBSCRIBER GROUP NO. AND/OR GROUP NAME		
	13. ARE OTHER FAMILY MEMBERS EMPLOYED? EMPLOYEE NAME SOC. SEC. NO.	14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13.		
15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN?	DENTAL PLAN NAME UNION LOCAL POLICY NO.	NAME AND ADDRESS OF CARRIER		

PATIENTS AUTHORIZATION: I hereby accept the above treatment plan and authorize the release of information relative to this course of treatment. I understand that I am responsible for the charges for any service not approved by benefit precertification review, for services which are not benefits of my dental plan or are rendered during any ineligible period and for the co-payments, deductibles and amounts exceeding the calendar year maximum of my dental plan. I understand that I may request a copy of the precertification review determination from Blue Shield of California.

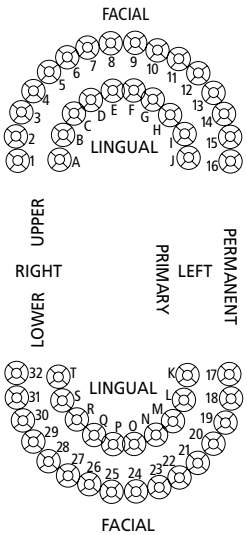
→ SIGNED (PATIENT OR PARENT IF MINOR) DATE

DENTIST INFORMATION

18. DENTIST SOC. SEC. OR T.I.N.	19. DENTIST LICENSE NO.	20. DENTIST PHONE NO.	27. ARE ANY SERVICES COVERED BY ANOTHER PLAN	YES	NO	
21. FIRST VISIT DATE CURRENT SERIES	22. PLACE OF TREATMENT OFFICE HOSP ECF OTHER	23. RADIOGRAPHS OR MODELS ENCLOSED? YES NO HOW MANY?	28. IF PROSTHESIS/CROWN IS THIS INITIAL PLACEMENT?			IF NO, THE REASON FOR REPLACEMENT / 29. DATE OF PRIOR PLACEMENT
24. IS TREATMENT RESULT OF OCCUPATION ILL NESS OR INJURY?	YES NO IF YES, ENTER BRIEF DESCRIPTION AND DATES		30. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED, ENTER / DATE APPLIANCES PLACED / MONTHS TREATMENT REMAINING
25. IS TREATMENT RESULT OF AUTO ACCIDENT? 26. OTHER ACCIDENT?		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

IDENTIFY MISSING TEETH WITH "**X**"



TOOTH NO. OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED ETC.)	DATE SERVICE PERFORMED MO.	DAY	YEAR	ADA PROCEDURE NUMBER	FEE	BLUE SHIELD USE ONLY ALLOWED AMOUNT
						TOTAL FEE ACTUALLY CHARGED		

REMARKS:

32. DENTIST'S NAME, ADDRESS, ZIP CODE & PROVIDER NUMBER