



**BlueCross BlueShield
of Wyoming**

An Independent Licensee of the Blue Cross
and Blue Shield Association

4000 House Avenue ** P O Box 2266
Cheyenne, WY 82003-2266

DENTAL CLAIM FORM

(Instructions for filing on second page)

PARTICIPANT'S NAME (Last, First, Middle)		ALPHA PREFIX / BCBS CARD NUMBER	
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Home address (Street, City, State, Zip)			IS THIS A NEW ADDRESS: <input type="checkbox"/> Yes <input type="checkbox"/> No
PATIENT'S NAME (Last, First, Middle)		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH ____ / ____ / ____ MM DD YYYY
		RELATIONSHIP TO PARTICIPANT	<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD

DESCRIBE THE ILLNESS, INJURY OR SYMPTOMS REQUIRING TREATMENT: _____

IF ILLNES OR INJURY RESULTED FROM AN ACCIDENT, WAS IT DUE TO:	INDICATE DATE OF ACCIDENT
AUTO <input type="checkbox"/> EMPLOYMENT <input type="checkbox"/> OTHER <input type="checkbox"/> (Briefly Describe) _____	____ / ____ / ____ MM DD YYYY

OTHER HEALTH INSURANCE: Is the patient covered by additional health insurance through an employer, a group such as a professional organization or any other group health insurance, including other Blue Cross and/or Blue Shield Coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please complete this section.		
NAME AND ADDRESS OF INSURING COMPANY (Street, City, State, Zip)	EFFECTIVE DATE ____ / ____ / ____ MM DD YYYY	TERMINATION DATE ____ / ____ / ____ MM DD YYYY
NAME OF POLICYHOLDER (Last, First, Middle)	DATE OF BIRTH ____ / ____ / ____ MM DD YYYY	IDENTIFICATION NUMBER (Including all letters & numbers)

I CERTIFY THAT THE ABOVE IS CORRECT AND COMPLETE AND THAT I AM CLAIMING BENEFITS ONLY FOR THE CHARGES INCURRED BY THE PATIENT NAMED ABOVE.

Signature of Participant

Date

INSTRUCTIONS FOR FILING CLAIMS

1. A separate claim form must be submitted for each family member.
2. Itemized bills for covered services, supplies and durable medical equipment **MUST** be attached and show:
 - A. Name of patient and date of birth
 - B. Date of service and charge for each
 - C. Type of services/supplies/equipment received (surgery, office calls, crutches, etc.)
 - D. Description of illness or accident
 - E. Date of accident
3. Bills for prescription medication must include above information as well as:
 - A. Patient's Name
 - B. Description of Illness or Accident
 - C. Name of Drug
 - D. Name of Drug Store
 - E. Prescribing Physician
 - F. Date Purchased and Charge for Each Drug
 - G. If actual drug receipt is not available, pharmacist signature is required
4. Questions on filing medical claims should be directed to:

Customer Service Center
Blue Cross Blue Shield of Wyoming
P O Box 2266
Cheyenne, WY 82003-2266
307.634.1393
1.800.442.2376 (in Wyoming)

NOTE: Balance due statements, cash register receipts, cancelled checks and cash receipts are **not** acceptable.

ITEMIZED BILLS CANNOT BE RETURNED SAMPLE OF BCBS IDENTIFICATION CARD

DOE, JOHN F.	(subscriber name)
ZSA 000000000	(BCBS card number)
XXXXX	960 460