UPMC Dental *Advantage*

**SUBSCRIBER SUBMITTED CLAIM FORM**

# Out-of-Network Care Claim Form

- Both sides of this form must be completed. Incomplete forms will delay payment.
- Complete sections 1 and 2. Have the doctor who treated you complete the Provider's Statement on the reverse side of this page.
- If your doctor does not complete the Provider's Statement on the reverse side of this page, you should attach itemized bills.
- Sign section 3 if you wish to have benefits paid directly to the doctor who treated you.
- UPMC Health Benefits will reimburse covered benefits only. Refer to your certificate of insurance or summary of benefits for details.
- If you have submitted a request for benefits to another plan, attach a copy of the bills you submitted to the other plan and the explanation of benefits you received from the other plan.

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**

**The bills must include:**

– patient's name
– patient's relationship to subscriber
– date of service
– type of services rendered
– charges for each service

- UPMC Health Benefits members should send this completed claim form and itemized bills to:

**UPMC Dental *Advantage***
**Claims Department**
**P.O. Box 1600**
**Pittsburgh, PA 15230-1600**

## To be completed by subscriber

<table>
<tr><td rowspan="2">1.Patient Information</td><td>Patient<br>First Name Middle Last</td><td>Relationship to Subscriber<br>☐ Self<br>☐ Child<br>☐ Spouse<br>☐ Other</td><td>Sex<br>☐ Male<br>☐ Female</td><td>Married<br>☐ Yes<br>☐ No</td><td>Patient Date of Birth<br>Mo./Day/Year</td></tr>
<tr><td>Subscriber SSN</td><td colspan="4">Name of Employer</td></tr>
<tr><td rowspan="6">2. Subscriber Information</td><td colspan="2">Subscriber<br>First Name Middle Last</td><td>Subscriber<br>Date of Birth</td><td colspan="2">Phone (area code)</td></tr>
<tr><td colspan="2">Mailing Address</td><td>City</td><td>State</td><td>Zip</td></tr>
<tr><td colspan="6">Is patient covered by another dental plan? ☐ Yes ☐ No (If Yes, complete the following:)</td></tr>
<tr><td>Dental Plan Name</td><td>Group</td><td colspan="4">Name and Address of Carrier</td></tr>
<tr><td colspan="2">I authorize release of any information relating to this claim</td><td colspan="4">I certify that the above information is correct.</td></tr>
<tr><td colspan="2">Date</td><td colspan="4">Date</td></tr>
<tr><td>3. Release Authorization</td><td colspan="2">Signature of Patient or<br>Signature of Authorized Representative if Minor</td><td colspan="4">Subscriber Signature</td></tr>
<tr><td></td><td colspan="6">If Authorized Representative, Relationship to Minor</td></tr>
</table>

# Provider's Statement

**To be completed by the treating dentist or supplier of service**

## Subscriber Information

**Name**

**SSN**

| Dentist Name | | Office Address | | City | State | Zip |
|---|---|---|---|---|---|---|
| Dentist Phone Number | Dentist License Number | Dentist SSN or T.I.N. | Provider Specialty Code | NPI (treating dentist) | NPI (billing entity, if different) | |
| First Visit Date Current Series | Place of Treatment<br>☐ Office<br>☐ Hospital<br>☐ ECF<br>☐ Other | Is treatment result of occupational illness or injury? ☐ Yes ☐ No<br>(If yes, enter brief description and dates.) | | Is treatment result of auto accident? ☐ Yes ☐ No<br>(If Yes, enter brief description and dates.) | | |
| Other Accident? ☐ Yes ☐ No<br>(If Yes, enter brief description and dates.) | | | Are any services covered by another plan? ☐ Yes ☐ No<br>(If Yes, enter brief description and dates.) | | | |
| If prosthesis, is this initial placement? ☐ Yes ☐ No<br>(If No, reason for replacement) | | Date of Prior Placement | Is treatment for orthodontia<br>☐ Yes ☐ No | If services already commenced, enter date appliance placed. | | |
| Months of Treatment Remaining | I Hereby Certify that the Services Listed Above<br>☐ Will Be ☐ Have Been Performed. | | Signature of Dentist | | Date Signed | |

## Record of Service Provided

| | Procedure Date (MM/DD/CCYY) | Areas of Oral Cavity | Tooth System | Tooth Number(s) or Letter(s) | Procedure Code | Description | Fee |
|---|---|---|---|---|---|---|---|
| 1 | | | | | | | |
| 2 | | | | | | | |
| 3 | | | | | | | |
| 4 | | | | | | | |
| 5 | | | | | | | |
| 6 | | | | | | | |
| 7 | | | | | | | |
| 8 | | | | | | | |
| 9 | | | | | | | |
| 10 | | | | | | | |

| Missing Teeth Information | Permanent | Primary | Other Fee(s) | |
|---|---|---|---|---|
| Place an "X" on each missing tooth. | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 | A B C D E F G H I J | | |
| | 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 | T S R Q P O N M L K | Total Fee | |

| **Billing Dentist or Dental Entity**<br>(Leave blank if dentist or dental entity is not submitting claim on behalf of patient or subscriber) | **Treating Dentist and Treatment Location Information** |
|---|---|
| | Name:_____<br>Address:_____ |




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