Subscriber ID: Subscriber: Claimant: Claim No.: Plan Sponsor:

BlueCross BlueShield of North Carolina

As Independent Licensee of the
Blue Cross and Blue Shield Associates

Dental Claim Coordination of Benefits

- Other Insurance Request Form

Dear Member:

Thank you for choosing BlueCross NC as your dental insurance carrier. We recently received a dental claim and to process your claim correctly, we will require additional information. Please complete this form and return it to the address listed at the end of the form you can email the completed form to documents@bcbsnc-dental.com. If you need help with the questionnaire, please call 1-800-305-6638. If you need more space, you may attach another sheet. We appreciate your attention to this matter.

If you or any member of your family did not have any other dental insurance in the past three years, you must complete Section I and III.

If you or any other member of your family were covered under another dental insurance carrier in the past three years, you must complete Sections I, II and III.

Section I.

Have you or anyone in your family had any other dental insurance in the past three years?

[ ] No

[ ] Yes – If yes; please complete section below and attach documentation stating legal responsibility for the dependent(s)dental coverage.

Policy Holder		**Social Security #**			
Date of Birth		**Telephone Number**			
Employer		**Insurance Company**			
Policy / Group		**Eff. Date**		**Term Date**	
Members Covered by this Plan					
Relationship to Policy Holder					
Name	**Date of Birth**				

Section II.

For Dependents of Divorced or Separated Parents under the age of 18. *(Defined as separated parents who were either married, never married, never together or together or married and no longer reside together in the same household.)*

Is there a dependent(s) on the policy under the age of 18?

[ ] No

[ ] Yes - If yes; please complete section below and attach documentation stating legal responsibility for the dependent's dental coverage.

Please state the full name of the parent in which the dependent(s) resides with for 6 months or more for the calendar year. If the dependent(s) reside at both parents equally throughout the calendar year, please state the word "equally" only. _____

Policy Holder		**Social Security #**			
Date of Birth		**Telephone Number**			
Employer		**Insurance Company**			
Policy / Group		**Eff. Date**		**Term Date**	
Members Covered by this Plan					
Relationship to Policy Holder					

Name	Date of Birth

Section III.

For Dependents of Divorced or Separated Parent over the age of 18, *i.e. Joint responsibility for dependents health coverage through college graduation.*

Is there a dependent(s) on the policy over the age of 18?

[ ] No

[ ] Yes - If yes; please complete section below and attach documentation stating legal responsibility for the dependent's dental coverage.

Name of Parent who has legal responsibility for the Dental Coverage:_____

Policy Holder		**Social Security #**			
Date of Birth		**Telephone Number**			
Employer		**Insurance Company**			
Policy / Group		**Eff. Date**		**Term Date**	
Members Covered by this Plan					
Relationship to Policy Holder					
Name	**Date of Birth**				

I hereby certify that the information on this form is accurate and complete. [ ]

_____

Signature **Date** **Daytime Phone**

Blue Cross NC Claims Unit
P.O. Box 2100
Winston-Salem, N.C.
27102-2100