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



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 <u>did not</u> 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.

Policy Holder Social Security # Date of Birth Telephone Number Eff. Date Term Date 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 married, 1 No the state of 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 # Telephone Number Employer Insurance Company Policy (Group Eff. Date Term Date Members Covered by this Plan	Section I.								
Policy Holder Social Security # Date of Birth Telephone Number Employer Date of Birth Date Of Birth Date Date Office Date Date Office Date Date Date Date Date Date Date Dat	Have you or anyone in your family ha	d any other dental insurance ir	n the past three	years?					
Policy Holder 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 Date of Birth Date of Birth Por 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 Date of Birth Telephone Number Employer Insurance Company Members Covered by this Plan Members Covered by this Plan	[] No								
Date of Birth	[] Yes – If yes; please complete sec	ion below and attach documen	tation stating l	egal responsib	ility for the d	ependent(s)dental co	verage.		
Date of Birth									
Employer Insurance Company	Policy Holder	-		Social Security #					
Policy / Group 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 logether 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 Insurance Company Policy / Group Members Covered by this Plan	Date of Birth			Telephone Number					
Members Covered by this Plan Relationship to Policy Holder Name Date of Birth 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 Date of Birth Telephone Number Employer Insurance Company Members Covered by this Plan	Employer			Insurance Company					
Relationship to Policy Holder Date of Birth 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 Date of Birth Telephone Number Employer Insurance Company Members Covered by this Plan	Policy / Group			Eff. Date		Term Date			
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 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? [] I 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 Policy / Group Members Covered by this Plan	Members Covered by this Plan			<u> </u>					
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? I No I 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 Policy / Group Members Covered by this Plan	Relationship to Policy Holder								
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 Date of Birth Telephone Number Employer Insurance Company Members Covered by this Plan	Name		Date of Birth						
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 Date of Birth Employer Policy / Group Members Covered by this Plan									
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 Date of Birth Telephone Number Employer Insurance Company Members Covered by this Plan									
Policy Holder Social Security # Date of Birth Telephone Number Employer Insurance Company Policy / Group Eff. Date Term Date	never together or together or married and Is there a dependent(s) on the policy [] No	d no longer reside together in the under the age of 18?	same househole	d.)					
Date of Birth Employer Insurance Company Policy / Group Eff. Date Term Date Members Covered by this Plan						endar year. If the dep	endent(s)		
Employer Insurance Company Policy / Group Eff. Date Term Date Members Covered by this Plan	Policy Holder				ty #				
Policy / Group Eff. Date Term Date Members Covered by this Plan	Date of Birth			Telephone Number					
Members Covered by this Plan	Employer			Insurance Company					
•	Policy / Group			Eff. Date		Term Date			
Relationship to Policy Holder	Members Covered by this Plan			•		•			
	Relationship to Policy Holder								

Name		Date of Birth						
graduation. Is there a depende [] No [] Yes - If yes; pl	of Divorced or Separated Parent over the agnt(s) on the policy over the age of 18? lease complete section below and attach does ho has legal responsibility for the Dental Cov	cumenta	·	,				
Policy Holder				Social Security	y #			
Date of Birth				Telephone Number				
Employer				Insurance Company				
Policy / Group				Eff. Date			Term Date	
Members Covered	d by this Plan							
Relationship to Po	olicy Holder							
Name			Date of Birth					
I hereby certify	that the information on this form is ac	curate a	and complet	e.[]				
Signatu	ure Date	Daytime Phone						
	Blue	Cross I	NC Claims Ur	it				

P.O. Box 2100
Winston-Salem, N.C.
27102-2100