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 Dental *Advantage* 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 Dental *Advantage* 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

1.Patient Information

Patient First Name	Middle	Last	Relationship to Subscriber ☐ Self ☐ Child ☐ Spouse ☐ Other	Sex ☐ Male ☐ Female	Married ☐ Yes ☐ No	Patient Date of Birth Mo./Day/Year
Subscriber SSN			Name of Employer			

2. Subscriber Information

Subscriber First Name	Middle	Last	Subscriber Date of Birth	Phone (area code)	
Mailing Address			City	State	Zip
Is patient covered by another dental plan? ☐ Yes ☐ No (If Yes, complete the following:)					
Dental Plan Name	Group	Name and Address of Carrier			
I authorize release of any information relating to this claim			I certify that the above information is correct.		

3. Release Authorization

Signature of Patient or Signature of Authorized Representative if Minor	Date	Subscriber Signature	Date
If Authorized Representative, Relationship to Minor			

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 ☐ Office ☐ Hospital ☐ ECF ☐ Other	Is treatment result of occupational illness or injury? ☐ Yes ☐ No (If yes, enter brief description and dates.)		Is treatment result of auto accident? ☐ Yes ☐ No (If Yes, enter brief description and dates.)		
Other Accident? ☐ Yes ☐ No (If Yes, enter brief description and dates.)			Are any services covered by another plan? ☐ Yes ☐ No (If Yes, enter brief description and dates.)			
If prosthesis, is this initial placement? ☐ Yes ☐ No (If No, reason for replacement)		Date of Prior Placement	Is treatment for orthodontia ☐ Yes ☐ No	If services already commenced, enter date appliance placed.		
Months of Treatment Remaining	I Hereby Certify that the Services Listed Above ☐ 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 (Leave blank if dentist or dental entity is not submitting claim on behalf of patient or subscriber)	**Treating Dentist and Treatment Location Information**
	Name:_____ Address:_____

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