



BlueCross BlueShield of South Carolina
 I-20 at Alpine Road
 Columbia, SC 29219-0001
 803.788.0222

SouthCarolinaBlues.com

BlueEssentialsSM Dental Reimbursement Form

Date: _____

Patient's Name: _____ Patient's DOB: ____/____/____
 Mo Day Year

Sex: ___Male ___Female

Membership ID#: _____

Insured's Name/Address: _____

Email Address: _____

Telephone Number: () _____ - _____ where you can most easily be reached

Date(s) of Service		Description of Service	Procedure Code	Reimbursement Amount
From MM DD YY	To MM DD YY			
		Exam #1 (1 every 6 months)	D0120	\$27.00
		Exam #2 (1 every 6 months)	D0120	\$20.00
		Cleaning #1 (age 13 or under-1 every 6 months)	D1120	\$31.00
		Cleaning #2 (age 13 or under-1 every 6 months)	D1120	\$31.00
		Cleaning #1 (age 14 or older -1 every 6 months)	D1110	\$40.00
		Cleaning #2 (age 14 or older -1 every 6 months)	D1110	\$40.00
TOTAL:				

Provider's Name: _____

Provider's Address: _____

Please send **completed form AND RECEIPTS/BILL FROM PROVIDER** any of these ways:

- Email: G&I.CLAIMS@BCBSSC.COM
- Fax: 1-803-264-0172
- Mail: BlueCross BlueShield of South Carolina
 G&I CLAIMS
 AX-H12
 P.O. Box 100300
 Columbia, SC 29202