BlueChoice® HealthPlan
South Carolina

An independent licensee of the
Blue Cross and Blue Shield Association

Dental Reimbursement Form

Patient's Name: ______________________________ Sex: ☐ Male ☐ Female

Patient's Birthdate: _____/_____/_____
MM DD YY

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Name: ______________________________

Insured's ID Number: ______________________________

Patient's Address (No., Street): ______________________________

City: ______________________________ State: ______________________________

ZIP Code: ______________________________ Telephone: (______) ______________________________

Date(s) of Service From: MM DD YY	To: MM DD YY	Description of Item or Service	Amount Paid	Procedure Code

Provider's Name: ______________________________

Provider's Address (No., Street): ______________________________

City: ______________________________ State: ______________________________

ZIP Code: ______________________________ Telephone: (______) ______________________________

Please submit a bill or receipt with the provider's name and address.

Claims Address:
BlueChoice HealthPlan
Claims Department
P.O. Box 6170
Columbia, SC 29260-6170
or fax to 803-735-9675