BlueCross BlueShield Nebraska

An independent licensee of the Blue Cross and Blue Shield Association

Reminder: This is a Dental Benefit that will be reimbursed to the **member.** Please submit a separate form for each date of service.

Dental Providers: If you are helping the member complete this form, please send it to the Eagan, MN processing center mailing address listed below. Please do not submit this claim to any other BCBSNE address.

Member Application for Dental Claim Reimbursement

Print, complete, sign and mail this form along with required documents:

Member ID: The Member ID and group number can be found on your Blue Cross and Blue Shield of Nebraska ID card

Member ID:	☐ Blue Cross and Blue Shield of Nebraska HMO Core ☐ Blue Cross and Blue Shield of Nebraska PPO Access ☐ Blue Cross and Blue Shield of Nebraska PPO Connect ☐ Blue Cross and Blue Shield of Nebraska Retiree Group PPO

Member information

Last Name:	First Name:		
Street Address:			
City:		State:	ZIP code:
Date of Birth:	Date of Service:	Total Charge for Date of Service: $	
Provider Name:	Provider NPI/TIN:		
Provider Address:			

To speed up processing of your request, please remember to:

- Complete one form for each member. Note: The dental provider can help you complete this form, but the reimbursement will be sent to the member.
- Mail only original clear itemized bill(s) on the provider's letterhead that includes the following:
  Date of Service, Provider Name, Charge Provider, and NPI/TIN

  The dentist office should provide this upon request. Without the information above, we cannot process your claim reimbursement and we will have to return it to you. Cash register receipts, cancelled checks, money orders, and personal itemizations are not accepted as original receipts.
- Keep copies of your documents for your files. We cannot return originals to you.
- **Mail this form and your original documents to the following address:**
  Blue Cross and Blue Shield of Nebraska, P. O. Box 211136, Eagan, MN 55121

I certify the above information is true, the enclosed material is correct and unaltered, and the expenses were incurred by the enrollee listed above. False receipts or altering of this information will result in civil or criminal prosecution. I authorize the release of any information as described below.

Member's signature:	Date:	Phone:

Your right to confidentiality: We will not release any information about you unless you ask us to in writing, or when release is necessary to process or review a claim (to another insurance company, for example). We will tell you which information we release and to whom, if you request it.