BlueCross BlueShield of North Carolina

An independent licensee Of the Blue Cross and Blue Shield Association

LIBERTY DENTAL PLAN

Member Submitted Dental Claim Form

Use this form to request reimbursement for covered supplemental dental services that have been completed and paid in full and not submitted by your dental provider.

- Do not use to file Medical or Part D Claims

Please attach the claim/provider information below required for reimbursement:

- Itemized statement including:
  - Procedure codes, treatment description,
  - Dates of service,
  - Cost of each procedure,
  - Any teeth numbers, teeth surfaces or mouth quadrants applicable.
- Receipt copies or invoices showing payment in full (no balance remaining)
- Provider information:
  - Provider name and address,
  - Office phone number,
  - National provider identifier (NPI) or state license number (if available)

Member Information

Member's Name		
Member's ID Number	Date of Birth	
Member's Address		
City	State	Zip
Signature:	Date:	

- ✓ Include all documentation.
- ✓ Make a copy of the documentation that you send to us for your records.
- ✓ Submit claims within 12 months of the date of service.

Send completed claim form and all required documentation to:

Liberty Dental Plan
Attn: Claims
PO Box 401086
Las Vegas, NV 89140

Email:
claims@libertydentalplan.com

Fax:
(949) 223-0011