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