South Carolina

BlueCross BlueShield of South Carolina
is an independent licensee of the
Blue Cross and Blue Shield Association

Dental Provider Reconsideration Form

Please complete this form for BlueCross BlueShield of South Carolina members to request a claim review. Use this form as the cover transmittal sheet for all supporting documentation. We will not consider submission of this form without supporting documentation. Complete or check each section, as appropriate.

Provider Information

Provider's Name: _____ NPI or Tax ID:_____

Phone Number: _____Ext:_____ Fax Number:_____

Contact Person: _____ Email:_____

Authorized Signature: _____ Date:_____

Patient Information

Patient's Name: _____ Member ID: _____

Claim Number: _____ Date of Service: _____

Please fax or mail to (select only one):

☐ State Dental Plan	Fax: 803-264-7739	Mail: AX-B15, P.O. Box 100300, Columbia, SC 29202
☐ BlueCross Commercial Dental	Fax: 803-264-7629	Mail: AX-D05, P.O. Box 100300, Columbia, SC 29202

Reconsideration

Brief Description of Request for Review:

_____
_____
_____
_____
_____
_____

Description of Documentation Included (required):_____

_____

Include all applicable documentation (e.g., pre- and post-op X-rays, periodontal charting and detailed office records) to expedite our review process.