MEDAVIE BLUE CROSS™

STANDARD DENTAL CLAIM FORM

644 MAIN ST PO BOX 220 MONCTON NB E1C 8L3 INQUIRIES: 1-800-667-4511
7 SPECTACLE LAKE DR DARTMOUTH PO BOX 2200 HALIFAX NS B3J 3C6 INQUIRIES: 1-800-667-4511
185 THE WEST MALL SUITE 1200 ETOBICOKE ON M9C 5P1 INQUIRIES: 1-800-355-9133

Canadian Dental Association / L'Association dentaire canadienne

Canadian Life and Health Insurance Association Inc.

PART 1 DENTIST

UNIQUE NO. | SPEC | PATIENT'S OFFICE ACCOUNT NO.

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.

SIGNATURE OF SUBSCRIBER

PATIENT

FIRST NAME LAST NAME

ADDRESS APT.

CITY PROV.

POSTAL CODE

DENTIST

PHONE NO.

FOR DENTIST'S USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION.

DUPLICATE FORM ☐

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY PLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREATMENT.
I ACKNOWLEDGE THAT THE TOTAL FEE OF $ _____ IS ACCURATE AND HAS BEEN CHARGED TO ME FOR SERVICES RENDERED.
I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY/PLAN ADMINISTRATOR. I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED TO THE COVERAGE OF SERVICES DESCRIBED IN THIS FORM TO THE NAMED DENTIST.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION

DATE OF SERVICE DAY	MO.	YR.	PROCEDURE CODE	INTL TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

FOR CARRIER USE

ALLOWED AMOUNT	INC	%	PATIENT'S SHARE

CHEQUE NO. | DATE

DEDUCTIBLE	PATIENT PAYS	PLAN PAYS

CLAIM NO.

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE.

TOTAL FEE SUBMITTED

INSTRUCTIONS FOR CLAIM SUBMISSION

BEING A STANDARD FORM, THIS FORM CANNOT INCLUDE SPECIFIC INSTRUCTIONS ON WHERE IT SHOULD BE SENT, DEPENDING ON WHO IS THE CARRIER FOR YOUR PLAN. YOU CAN OBTAIN DETAILS FROM EITHER YOUR PLAN BOOKLET, YOUR CERTIFICATE OR FROM YOUR EMPLOYER.
IF YOUR PLAN REQUIRES SUBMISSION DIRECTLY TO THE CARRIER, PLEASE SEND THIS FORM WITH ONLY PARTS 1, 2 AND 3 COMPLETED TO THE CARRIER'S APPROPRIATE CLAIMS OFFICE.
IF YOUR PLAN REQUIRES SUBMISSION TO YOUR EMPLOYER, PLEASE DIRECT THIS FORM TO YOUR PERSONNEL OFFICE PLAN ADMINISTRATOR WHO WILL COMPLETE PART 4 AND FORWARD THE FORM TO THE CARRIER.

PART 2 - EMPLOYEE/PLAN MEMBER/SUBSCRIBER

1. POLICY NO. _____
   EMPLOYER _____
   NAME OF INSURING AGENCY OR PLAN _____
2. YOUR NAME (PLEASE PRINT) _____
   YOUR CERT. NO. OR S.I.N. OR I.D. NO. _____
   YOUR DATE OF BIRTH _____ (DAY MO. YR.)

PART 3 - PATIENT INFORMATION

1. RELATIONSHIP TO EMPLOYEE/PLAN MEMBER/SUBSCRIBER _____
   DATE OF BIRTH _____ (DAY MO. YR.) IF CHILD, INDICATE STUDENT ☐ HANDICAPPED ☐
   IF STUDENT, INDICATE SCHOOL _____
   PATIENT I.D. NO. _____
2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN, W.C.B. OR GOV'T PLAN? NO ☐ YES ☐
   POLICY NO. _____ SPOUSE DATE OF BIRTH _____ (DAY MO. YR.)
   NAME OF OTHER INSURING AGENCY OR PLAN _____
3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? IF YES, GIVE DATE AND DETAILS SEPARATELY. NO ☐ YES ☐
4. IF TREATMENT INCLUDES DENTURE, CROWN OR BRIDGE, IS THIS AN INITIAL PLACEMENT? IF NO, GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT. NO ☐ YES ☐
   _____ (DAY MO. YR.)
5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? NO ☐ YES ☐
6. I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO THE INSURER/PLAN ADMINISTRATOR AND CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE. CLAIMING BENEFITS IMPLIES CONSENT TO BLUE CROSS PRIVACY PROTECTION PRACTICES.

SIGNATURE OF PATIENT (PARENT/GUARDIAN) _____ DATE (DD/MM/YY) _____

PART 4 - POLICYHOLDER / EMPLOYER (FOR COMPLETION ONLY IF APPLICABLE. SEE ABOVE*)

	DAY	MO.	YR.
1. DATE COVERAGE COMMENCED			
2. DATE DEPENDENT COVERED			
3. DATE TERMINATED			

4. CONTRACT HOLDER — DATE (DAY MO. YR.)

AUTHORIZED SIGNATURE

(POSITION OR TITLE)

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