

PART 1 - DENTAL SERVICE PROVIDER

P A T I E N T	Last Name	Given Name	P R O V I D E R	Unique Number	Specialty	I hereby assign my benefits payable from this claim to the named provider and authorize payment directly to him/her. _____ Signature of subscriber																																																																																													
	Address			Telephone Number:																																																																																															
	City	Province					Postal Code																																																																																												
	Patient Identification Number			<input type="checkbox"/> Duplicate Form																																																																																															
<p>PROVIDER'S USE ONLY - For additional information, diagnosis, procedures or special considerations.</p> <p>Referred by: Name _____</p> <p>Was this emergency treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes - If yes, please provide additional details.</p> <p>ATTACHMENTS <input type="checkbox"/> Radiographs (large/small) <input type="checkbox"/> Models <input type="checkbox"/> Photographs <input type="checkbox"/> Written Diagnostic Report</p>																																																																																																			
<p>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 the provider for the entire treatment.</p> <p>I acknowledge that the total fee of \$ _____ is accurate and has been charged to me for services rendered.</p> <p>I authorize release of the information contained in this claim form to my insuring company / plan administrator. I also authorize communication of information related to the coverage of services described in this form to the named dental provider.</p> <p style="text-align:right;">Signature of Patient (Parent/Guardian) _____</p> <p style="text-align:right;">OFFICE VERIFICATION: Dentist/ Denturist Signature: _____</p>																																																																																																			
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2"></th> <th colspan="3">DATE OF SERVICE</th> <th rowspan="2">PROCEDURE CODE</th> <th rowspan="2">TOOTH CODE</th> <th rowspan="2">TOOTH SURFACES</th> <th rowspan="2">PROFESSIONAL FEE</th> <th rowspan="2">LABORATORY CHARGE</th> </tr> <tr> <th>YYYY</th> <th>MM</th> <th>DD</th> </tr> </thead> <tbody> <tr><td>1</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>2</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>3</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>4</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>5</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>6</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>7</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>8</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>9</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table>								DATE OF SERVICE			PROCEDURE CODE	TOOTH CODE	TOOTH SURFACES	PROFESSIONAL FEE	LABORATORY CHARGE	YYYY	MM	DD	1									2									3									4									5									6									7									8									9								
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PART 2 - SUBSCRIBER INFORMATION NOTE: If the Subscriber's address has changed since the last claim was made, please contact your benefit plan administrator with the new address.

Surname	Given Name	Subscriber's Signature: I hereby declare this claim is for an eligible dependent as defined under my dental benefit coverage and all information is correct and complete to the best of my knowledge. I authorize the following to exchange information needed to determine my eligibility for coverage, to verify, assess and pay claims, and to administer the benefit plan: Alberta Blue Cross, health care professionals/practitioners/institutions, health benefits providers or insurance companies.					
Group	Class					Subscriber Identification Number	
Telephone Number(s) During Business Hours						Subscriber's Date of Birth	
		YYYY MM DD					

PART 3 - PATIENT INFORMATION (Refer to I.D. card)

Patient's Relationship to Subscriber:				Patient's Date of Birth			
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other (Specify): _____				YYYY MM DD			
Do you have any additional Blue Cross Plans that would provide dental benefits? <input type="checkbox"/> No <input type="checkbox"/> Yes - If yes, please complete the following:		Do you have any other coverage with another carrier that would provide dental benefits? <input type="checkbox"/> No <input type="checkbox"/> Yes - If yes, please complete the following:		If service claimed is a Denture, Bridge or Crown, is this an initial placement? <input type="checkbox"/> No - Please indicate type and age of prosthesis being replaced, the reason for replacement and teeth missing. <input type="checkbox"/> Yes - If partial denture or bridge, please indicate which teeth are being replaced & date(s) they were extracted.			
Name of Employer		Insuring Company Name or Name of Employer					
Subscribers Name		Name of Insured					
Date of Birth YYYY MM DD		Date of Birth YYYY MM DD					
Blue Cross Group and Identification Number		Policy Identification Numbers					
If Other Plan is no longer in effect please state: Cancellation Date YYYY MM DD		If Other Plan is no longer in effect please state: Cancellation Date YYYY MM DD		Was treatment the result of an accident? <input type="checkbox"/> No <input type="checkbox"/> Yes - If yes, please complete the reverse side of this page.			

ACCIDENT REPORT

PRACTITIONER'S REPORT OF INJURY (Please indicate tooth codes, extent of damage and forward appropriate radiographs.)

SUBSCRIBER'S REPORT OF ACCIDENT

DATE ACCIDENT OCCURRED	YYYY	MM	DD	LOCATION OF ACCIDENT
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PLEASE STATE THE CIRCUMSTANCES LEADING TO AND MATTERS CAUSING THE ACCIDENT

Are any services being claimed through the Workers' Compensation Board?

No Yes - If yes please provide details: _____

If injury is the result of a Motor Vehicle Accident or an Assault, please provide the following:

- a) Copy of police report
- b) Full name, address and telephone number of any witness(s) to the accident

DATE	SUBSCRIBER'S SIGNATURE
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