

## STANDARD DENTAL CLAIM FORM

644 MAIN ST PO BOX 220 MONCTON NB E1C 8L3 INQUIRIES: 1-800-667-4511 230 BROWNLOW AVE 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 Life and Health Insurance Association Inc.

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PART 1 DENTIST	UNIQUE NO.	JNIQUE 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 HIMHER.			
P A FIRST NAME         LAST NAME           T ADDRESS         APT.           E N CITY         PROV.	D E N T I					PAYMENT	DIRECT	LYTOF	шмнен.		
T POSTAL CODE T PHONE NO								SIGNATURE OF SUBSCRIBER			
FOR DENTIST'S USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION.				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 \$							
DUPLICATE FORM L				OFFICE VERIFICATION							
DATE OF SERVICE PROCEDURE CODE INTL TOOTH SURFACE		DENTIST'S FEE L		TOTAL CI	FOR CARRIER USE						
DATI NIO. 111.			CHARGE			ALLOWED AMOUNT	INC		PATIENT'S SHARE		
						CHEQUE NO.		DATE			
<del></del>									DI ANI DAVO		
						DEDUCTIBLE	PATIEN PAYS	П	PLAN PAYS		
THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE	TOTAL FEE SU	JBMITTED				CLAIM NO.					
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											
NAME OF INSURING AGENCY OR PLAN YOUR DATE OF BIRTH											
DATE OF BIRTH DAY MO. YR. IF CHILD, INDICATE STUDENT HANDICAPPED DAY MO. YR. 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.  4. IF TREATMENT INCLUDES DENTURE, CROWN OR BRIDGE, IS THIS AN INITIAL PLACEMENT? IF NO, GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT.  DAY MO. YR.  5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES?  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/YYYY)  PART 4 - POLICYHOLDER / EMPLOYER (FOR COMPLETION ONLY IF APPLICABLE. SEE ABOVE*)											
1. DATE COVERAGE COMMENCED 2. DATE DEPENDENT COVERED 3. DATE TERMINATED	4. CONTRACT HOI	LDER	DATE MO. YR.			AUTHORIZE (POSITIO					