



DENTAL CLAIM FORM

DATE RECEIVED

DENTIST / DENTURIST	DENTIST/DENTURIST NO.	DENTIST/DENTURIST NAME
	ADDRESS	
	CITY/PROVINCE	POSTAL CODE
	SERVICES FOR BENEFITS HAVE BEEN: <input type="checkbox"/> PERFORMED <input type="checkbox"/> PLANNED PRE-AUTHORIZATION REQUIRED FOR ALL ACCOUNTS \$500.00 OR MORE.	
	WAS SERVICE THE RESULT OF: A MOTOR VEHICLE ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO AN INJURY AT THE WORKPLACE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE DETAILS _____	
EMPLOYEE	ARE ANY BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER INSURANCE OR PLAN FOR THE EXPENSES CLAIMED? IF BLUE CROSS IS SECOND INSURER PLEASE ATTACH A STATEMENT OF PAYMENT OR DENIAL FROM FIRST INSURER. <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, COMPLETE THE FOLLOWING POLICYHOLDER UNDER OTHER PLAN _____ BIRTHDATE _____ / _____ / _____ DAY MONTH YEAR EMPLOYER _____ EMPLOYER'S INSURANCE COMPANY _____ POLICY OR CONTRACT NUMBER _____	

CONTRACT NUMBER		GROUP NUMBER
SURNAME	FIRST NAME	
ADDRESS		BIRTHDATE
		DAY MON YEAR
CITY	PROVINCE	POSTAL CODE
HAS YOUR ADDRESS CHANGED IN THE PAST 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO		
PATIENT INFORMATION MUST BE GIVEN PATIENT'S FIRST NAME		BIRTHDATE DAY MON YEAR
RELATIONSHIP TO EMPLOYEE <input type="checkbox"/> 1 SELF <input type="checkbox"/> 2 SPOUSE <input type="checkbox"/> 3 DEPENDENT		
PHONE	HOME:	OFFICE:
I CERTIFY THAT I AM AWARE OF AND HAVE READ THE AUTHORIZATION AND CONSENT ON THE REVERSE SIDE OF THIS CLAIM FORM. I UNDERSTAND THAT THE CHARGES LISTED MAY NOT BE COVERED BY OR MAY EXCEED MY POLICY BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST/DENTURIST FOR THE ENTIRE COST OF THE TREATMENT.		
IS PAYMENT TO BE MADE TO THE PROVIDER OF SERVICE? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE SIGN HERE _____ SIGNATURE OF PATIENT (OR PARENT/GUARDIAN)		

IF PATIENT IS A DEPENDENT CHILD OVER THE AGE OF 18, PLEASE COMPLETE THE FOLLOWING:

- AGE OF THE CHILD _____
- IS HE/SHE MARRIED? YES NO
- IS HE/SHE EMPLOYED FULL-TIME? YES NO
- IS HE/SHE IN FULL-TIME ATTENDANCE AT SCHOOL, COLLEGE, OR UNIVERSITY? YES NO
- IS HE/SHE PHYSICALLY OR MENTALLY INCAPACITATED AND DEPENDENT ON YOU FOR SUPPORT? YES NO

3 - DENTIST/DENTURIST Examination and Treatment Record								BLUE CROSS USE ONLY		
SERVICES PERFORMED			TOOTH CODE	PROCEDURE NUMBER	SPECIFIC SURFACES FILLED	SERVICE MATERIAL	QTY. OR UNITS	AMOUNT BILLED	BLUE CROSS PAYS	REJECT REASON
DAY	MON	YEAR	INT. NO.							

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE ARE CORRECT AND REPRESENT THOSE RENDERED TO THE PATIENT NAMED.

DENTIST'S/DENTURIST'S SIGNATURE _____ DATE: _____

AUTHORIZATION AND CONSENT

I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by Manitoba Blue Cross and/or Blue Cross Life Insurance Company of Canada may be collected, used, or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, to develop and recommend suitable products and services to me, and to manage the Company's business.

Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These include other Blue Cross organizations, licensed physicians and/or any other healthcare professionals or institutions, health and life insurers, government and regulatory authorities, the certificate holder of any policy under which I am a participant and other third parties when required to administer the benefits outlined in my policy or the group policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Blue Cross' privacy policies I can contact Blue Cross at 775-0151 or toll free at 1-800-873-2583 or www.mb.bluecross.ca should I have questions as to the collection, use or disclosure of my personal information.

I authorize Blue Cross to collect, use and disclose my personal information as described above.