BIGSTONE NON-INSURED HEALTH DENTAL BENEFITS REIMBURSEMENT FORM

BIGSTONE CORPORATE OFFICE 16310-100 AVE EDMONTON, AB T5P 4X5

PLEASE MAIL IN OR DROP FORM OFF AT ABOVE ADDRESS WITH PROOF OF PAYMENT AND DENTAL CLAIM FORM(S) ATTACHED

_____ _____ _____

Surname **Given Name** **Date of birth (MM/DD/YR)**

_____

Treaty number

***If client is under one year old and not registered please provide parents:**

_____ _____ _____ _____

Surname **Given Name** **Treaty #** **D.O.B (MM/DD/YR)**

CLAIM INFORMATION

DATE OF SERVICE	PROCEDURE CODE	TOOTH CODE	AMOUNT CLAIMED	AMOUNT PAID

***PLEASE NOTE THAT ALL FEES ARE PAID IN ACCORDANCE WITH NIHB FEE GUIDELINES**

Total: _____

PROVIDERS INFORMATION

_____

Providers Name

_____

Address

_____

Telephone Number

Payees Information *Please note payee must be 18 years of age or older

_____

Payees Name

_____

Address

I certify that these items or services were received by me and that no parts of these costs were paid under another plan or coverage.

_____ _____

Clients Signature **Date**

_____ _____ _____ **REIM**_____

Authorizing officer Signature **Authorizing code** **Date** **Number**