

STANDARD DENTAL CLAIM FORM

644 MAIN ST PO BOX 220 7 SPECTACLE LAKE DR DARTMOUTH MONCTON NB E1C 8L3 1NQUIRIES: 1-800-667-4511 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.

Tansdeme -																														
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						
Р	P D D E FIRST NAME LAST NAME E																			DIRECTLY TO HIM/HER.										
A T	ADDRECC									1																				
I E	CITY PROV.																													
N T							, FNC	Jv		-																				
POSTAL CODE PHONE NO FOR DENTIST'S USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR													1111	NDEE	STAND TI	нат т	HEF	- FFSI	ISTE	SIGNATURE OF SUBSCRIBER										
	EN I AC TO I AL CO															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 CHARGEI TO ME FOR SERVICES RENDERED. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED INTHIS 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.												THE CHARGED NG		
DUF	LICATE	E FORM	л <u>Г</u>													OF	SIGNATURE OF PATIENT (PARENT/GUARDIAN)													
DATE	DATE OF SERVICE PROCEDURE CODE INTL TOOTH										DENTIST'S FEE					OFFICE VERIFICATION LABORATORY TOTAL CHARGES														
	MO.	THOOLDONE GODE				HCODE	SURFACES	<u> </u>	DENTIST			''			CHARGE			TOTAL CH			T	FC ALLOWED AMOUNT		OR CARRIER U		SE PATIENT'S SHARE				
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THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE. TOTAL FEE SUBMITTED																<u> </u>					CLAIN	 M NO.								
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IF YO	UR PLA	AN REG	UIRES	SUBMIS	SION D	DIREC	CTLY TO	O THE	CARRIER, PL	EASE	SEND														PRIATE CLAIMS 4 AND FORWA			O THE C	ARRIER.	
PA	RT 2	- EM	PLO'	YEE/F	LAN	N MI	EMB	ER/	SUBSCR	IBEF	}																			
1. POLICY NO																														
E	EMPLOYER													YOUR CERT. NO. OR S.I.N. OR I.D. NO.																
١	NAME OF INSURING AGENCY OR PLAN													YOUR DATE OF BIRTH DAY MO YE																
PART 3 - PATIENT INFORMATION																														
1. F	RELATIO	ONSHII	PTO E	//PLOYE	EE/PL/	AN M	EMBE	R/SU	BSCRIBER						_									RESULT						
[DATE OF BIRTH													ACCIDENT? IFYES, GIVE DATE AND DETAILS SEPARATELY. NO YES 4. IF TREATMENT INCLUDES DENTURE, CROWN OR BRIDGE, IS THIS NO YES																
IF STUDENT, INDICATE SCHOOL													AN INITIAL PLACEMENT? IF NO, GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT.																	
PATIENT I.D. NO													DAY MO. YR.																	
INSURANCE OR DENTAL PLAN, W.C.B. OR GOV'T PLAN? NO YES												5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? NO YES																		
POLICY NO SPOUSE DATE OF BIRTH DAY MO. YR. NAME OF OTHER INSURING AGENCY OR PLAN													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.																	
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1. [DAY MO. YR. 1. DATE COVERAGE COMMENCED 1. DATE COVERAGE COMMENCED 4. CONTRACT HOLDER											DAT	DATE ————————————————————————————————————								AUTHORIZED SIGNATURE									
2. DATE DEPENDENT COVERED											DAY	MO. YR.								(POSITION OR TITLE)										