

**PART 1 - DENTAL SERVICE PROVIDER**

<b>P A T I E N T</b>	<b>Last Name</b>	<b>Given Name</b>	<b>P R O V I D E R</b>	<b>Unique Number</b>	<b>Specialty</b>	I hereby assign my benefits payable from this claim to the named provider and authorize payment directly to him/her.  _____ Signature of member	
	<b>Address</b>						
	<b>City</b>	<b>Province</b>					<b>Postal Code</b>
	<b>Patient ID Number</b>			<b>Telephone Number:</b>			
			<input type="checkbox"/> Duplicate Form		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. I acknowledge that the total fee of \$ _____ is accurate and has been charged to me for services rendered. 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. <b>Signature of Patient</b> (Parent / Guardian) _____ OFFICE VERIFICATION: Dentist / Denturist Signature: _____		

**PROVIDER'S USE ONLY** - For additional information, diagnosis, procedures or special considerations.

**Referred by: Name** \_\_\_\_\_

**Was this emergency treatment?**  No  Yes - If yes, please provide additional details.

**ATTACHMENTS**  Radiographs (large/small)  Models  Photographs  Written Diagnostic Report

	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								

This is an accurate statement of services performed and the total fee due and payable, E. & O.E. **Total Fee Submitted** >

**PART 2 - MEMBER INFORMATION** NOTE: If the Member's address has changed since the last claim was made, please contact your benefit plan administrator with the new address.

<b>Surname</b>		<b>Given Name</b>		<b>Member's Signature:</b> 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 or my dependent's 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.
<b>Group</b>	<b>Class</b>	<b>Member ID Number</b>		
<b>Telephone Number(s) During Business Hours</b>		<b>Member's Date of Birth</b>		
		YYYY MM DD		

**PART 3 - PATIENT INFORMATION (Refer to ID card)**

<b>Patient's Relationship to Member:</b>			<b>Patient's Date of Birth</b>		
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other (Specify): _____			YYYY MM DD		
<b>Do you have any additional Blue Cross Plans that would provide dental benefits?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes - If yes, please complete the following:		<b>Do you have any other coverage with another carrier that would provide dental benefits?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes - If yes, please complete the following:		<b>If service claimed is a Denture, Bridge or Crown, is this an initial placement?</b> <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			
Member's Name		Date of Birth		Name of Insured	
		YYYY MM DD			
Blue Cross Group and ID Number		If Other Plan is no longer in effect please state: Cancellation Date		Policy Identification Numbers	
		YYYY MM DD			
		If Other Plan is no longer in effect please state: Cancellation Date			
		YYYY MM DD			
<b>Was treatment the result of an accident?</b> <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.)


## MEMBER'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	MEMBER'S SIGNATURE
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