

**DENTAL  TREATMENT PLAN**

**CLAIM** Verification No.: \_\_\_\_\_

**PART 1 - DENTAL SERVICE PROVIDER**

<b>P A T I E N T</b>	Last Name _____ Given Name _____		<b>P R O V I D E R</b>	Unique Number _____ Specialty _____		I hereby assign my benefits payable from this claim to the named provider and authorize payment directly to him/her.  _____ Signature of subscriber	
	Address _____			Telephone Number: _____			
	City _____ Province _____ Postal Code _____			<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: _____
	Patient Identification Number _____						
<b>PROVIDER'S USE ONLY</b> - For additional information, diagnosis, procedures or special considerations.  Referred by: Name _____ Was this emergency treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes - If yes, please provide additional details.							
<b>ATTACHMENTS</b> <input type="checkbox"/> Radiographs (large/small) <input type="checkbox"/> Models <input type="checkbox"/> Photographs <input type="checkbox"/> 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.							<b>Total Fee Submitted</b> >
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**PART 2 - SUBSCRIBER INFORMATION** NOTE: If the Subscriber's address has changed since the last claim was made, please contact your benefit plan administrator with the new address.

Surname _____ Given Name _____		<b>Subscriber'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.
Group _____	Class _____ Subscriber Identification Number _____	
Telephone Number(s) During Business Hours _____		
Subscriber's Date of Birth YYYY MM DD _____		

**PART 3 - PATIENT INFORMATION (Refer to I.D. card)**

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


## SUBSCRIBER'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	SUBSCRIBER'S SIGNATURE
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