10009-108 Street NW, Edmonton, Alberta T5J 3C5

DENTAL ☐ TREATMENT PLAN ☐ CLAIM

Verification No.: ____________

PART 1 - DENTAL SERVICE PROVIDER

PATIENT

Last Name | Given Name

Address

City | Province | Postal Code

Patient Identification Number

PROVIDER

Unique Number | Specialty

Telephone Number:

I hereby assign my benefits payable from this claim to the named provider and authorize payment directly to him / her.

Signature of subscriber

☐ Duplicate Form

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.

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.

Signature of Patient (Parent / Guardian) ____________

OFFICE VERIFICATION: Dentist / Denturist Signature:

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

	DATE OF SERVICE YYYY | MM | DD	PROCEDURE CODE	TOOTH CODE	TOOTH SURFACES	PROFESSIONAL FEE	LABORATORY CHARGE
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
This is an accurate statement of services performed and the total fee due and payable, E. & O.E.					**Total Fee Submitted >**	

PART 2 - SUBSCRIBER INFORMATION

Group | Class | **Subscriber Identification Number** | Surname | Given Name

Telephone Number(s) During Business Hours | Subscribers Date of Birth YYYY MM DD

Subscriber's Signature: (I acknowledge that the above treatment has been rendered and the patient for whom this claim is made is an eligible dependent under my plan.)

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

Patient's Relationship to Subscriber:

☐ Self ☐ Spouse ☐ Son ☐ Daughter ☐ Other (Specify):

Patient's Date of Birth YYYY MM DD

Do you have any additional Blue Cross Plans that would provide dental benefits?

☐ **No** ☐ **Yes** - If yes, please complete the following:

Name of Employer

Subscribers Name | 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Blue Cross Group and Identification Number | If Other Plan is no longer in effect please state: Cancellation Date YYYY MM DD

Do you have any other coverage with another carrier that would provide dental benefits?

☐ **No** ☐ **Yes** - If yes, please complete the following:

Insuring Company Name or Name of Employer

Name of Insured | Date of Birth 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?

☐ **No** - Please indicate type and age of prosthesis being replaced, the reason for replacement and teeth missing.

☐ **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?

☐ **No** ☐ **Yes** - If yes, please complete page two.

ABC 20041 (WEB)

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ACCIDENT REPORT

PRACTIONER'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

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