



**Part 1 - Dental service provider**

<b>P A T I E N T</b>	Last name		First name		<b>P R O V I D E R</b>	Unique number	Specialty	Patient's office account number	I hereby assign my benefits payable from this claim to the named provider and authorize payment directly to him/her.	
	Address									
	City		Province	Postal Code						
	Patient ID number					Telephone number				Signature of member

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

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.

Referred by	Was this emergency treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please provide additional details	Signature of patient (Parent/Guardian)
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Attachments <input type="checkbox"/> Radiographs (large/small) <input type="checkbox"/> Models <input type="checkbox"/> Photographs <input type="checkbox"/> Written diagnostic report	Office verification: Dentist/denturist signature
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	Date of service (YYYY/MM/DD)	Procedure code	Tooth code	Tooth surfaces	Professional fee	Laboratory charge
1						
2						
3						
4						
5						
6						
7						

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 - Primary plan member** NOTE: If the member's address has changed since the last claim was made, please contact your benefit plan administrator with the new address.

Last name		First name		I hereby declare this claim is for an eligible dependant as defined under my dental benefit coverage and all information is correct and complete to the best of my knowledge.	
Group	Class	Member ID number	I authorize the following to exchange information needed to determine my or my dependant'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.		
Telephone number(s) during business hours		Member's date of birth (YYYY/MM/DD)		Signature of member	Date (YYYY/MM/DD)

**Part 3 - Patient information (refer to ID card)**

<b>Patients' relationship to member:</b> <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____				<b>Patient's date of birth</b>			YYYY	MM	DD	<b>If service claimed is a denture, bridge or crown, is this an initial placement?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes
<b>Do you have any additional Alberta 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.				NO Please indicate the type and age of the prosthesis being replaced, the reason for replacement and teeth missing. YES If partial denture or bridge, please indicate which teeth are being replaced and date(s) they were extracted.		
Name of employer				Insuring company name or name of employer						
Member's name				Name of insured						
Alberta Blue Cross group and ID number		Member date of birth (YYYY/MM/DD)		Policy ID number		Insured date of birth (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.	
If other plan is no longer in effect, please state cancellation date		YYYY	MM	DD	If other plan is no longer in effect, please state cancellation date		YYYY	MM		DD

# ACCIDENT REPORT

**Practitioner's report of injury (please indicate tooth codes, extent of damage and forward appropriate radiographs)**

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## Plan 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? Yes No If yes, please provide details:

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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 witnesses to the accident.

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Date (YYYY/MM/DD)	Primary plan member's signature
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**ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL.**  
**Acknowledgement and consent to release this information is provided on the front of this form.**