ALBERTA BLUE CROSS®

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

DENTAL ☐ TREATMENT PLAN

☐ CLAIM Verification No.: _____

PART 1 - DENTAL SERVICE PROVIDER

PATIENT

Last Name | First Name

Address

City | Province | Postal Code

Patient ID 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 member

☐ 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. I also authorize communication of information related to the coverage of services described in this form to the named dental provider.

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						

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.

Last Name | Given Name

Group | Class | **Member ID Number** –

Telephone Number(s) During Business Hours

Member's Date of Birth YYYY MM DD

Member's Signature:
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.

PART 3 - PATIENT INFORMATION (Refer to ID card)

Patient's Relationship to Member:
☐ 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

Member's Name | Date of Birth YYYY MM DD

Blue Cross Group and ID 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 the reverse side of this page.

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

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

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

Acknowledgement and consent to release this information is provided on the front of this form.