ALBERTA BLUE CROSS®

10009 108 Street NW, Edmonton, Alberta T5J 3C5

DENTAL ☐ **TREATMENT PLAN**

☐ **CLAIM**

Verification number: _____

Part 1 - Dental service provider

PATIENT			PROVIDER				
Last name	First name		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 subscriber

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?** ☐ No ☐ Yes If yes, please provide additional details	Signature of patient (Parent/Guardian)
Attachments ☐ Radiographs (large/small) ☐ Models ☐ Photographs ☐ Written diagnostic report	Office verification: Dentist/denturist signature

	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.					**Total Fee Submitted**	

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. 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.
Group	Class	Member ID number		
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)*

Patients' relationship to member: ☐ Self ☐ Spouse ☐ Child ☐ Other_____		**Patient's date of birth** (YYYY/MM/DD)	**If service claimed is a denture, bridge or crown, is this an initial placement?** ☐ No ☐ Yes
Do you have any additional Alberta Blue Cross Plans that would provide dental benefits? ☐ No ☐ Yes If yes, please complete the following.		**Do you have any other coverage with another carrier that would provide dental benefits?** ☐ No ☐ 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)
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)	**Was treatment the result of an accident?** ☐ No ☐ 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)***

Plan 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? ☐Yes ☐No 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 witnesses to the accident.	
Date (YYYY/MM/DD)	Primary plan member's signature

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL.

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