MANITOBA BLUE CROSS®

# DENTAL CLAIM FORM

DATE RECEIVED

## DENTIST/DENTURIST

DENTIST/DENTURIST NO. | DENTIST/DENTURIST NAME

ADDRESS

CITY/PROVINCE | POSTAL CODE

SERVICES FOR BENEFITS HAVE BEEN:

☐ PERFORMED ☐ PLANNED

PRE-AUTHORIZATION REQUIRED FOR ALL ACCOUNTS $500.00 OR MORE.

WAS SERVICE THE RESULT OF:

A MOTOR VEHICLE ACCIDENT? ☐ YES ☐ NO

AN INJURY AT THE WORKPLACE? ☐ YES ☐ NO

IF YES, GIVE DETAILS _____

## EMPLOYEE

CONTRACT NUMBER | GROUP NUMBER

SURNAME | FIRST NAME

ADDRESS | BIRTHDATE DAY MON YEAR

CITY PROVINCE | POSTAL CODE

HAS YOUR ADDRESS CHANGED IN THE PAST 12 MONTHS? ☐ YES ☐ NO

## PATIENT

PATIENT INFORMATION MUST BE GIVEN
PATIENT'S FIRST NAME | BIRTHDATE DAY MON YEAR | RELATIONSHIP TO EMPLOYEE ☐ 1 SELF ☐ 2 SPOUSE ☐ 3 DEPENDENT

PHONE HOME: OFFICE:

## EMPLOYEE

ARE ANY BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER INSURANCE OR PLAN FOR THE EXPENSES CLAIMED?

IF BLUE CROSS IS SECOND INSURER PLEASE ATTACH A STATEMENT OF PAYMENT OR DENIAL FROM FIRST INSURER.

☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING

POLICYHOLDER UNDER OTHER PLAN _____

BIRTHDATE _____ / _____ / _____
DAY MONTH YEAR

EMPLOYER _____

EMPLOYER'S INSURANCE COMPANY _____

POLICY OR CONTRACT NUMBER _____

## PATIENT/SUBSCRIBER

I CERTIFY THAT I AM AWARE OF AND HAVE READ THE AUTHORIZATION AND CONSENT ON THE REVERSE SIDE OF THIS CLAIM FORM. I UNDERSTAND THAT THE CHARGES LISTED MAY NOT BE COVERED BY OR MAY EXCEED MY POLICY BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST/DENTURIST FOR THE ENTIRE COST OF THE TREATMENT.

IS PAYMENT TO BE MADE TO THE PROVIDER OF SERVICE?

☐ YES ☐ NO

PLEASE SIGN HERE

_____
SIGNATURE OF PATIENT (OR PARENT/GUARDIAN)

IF PATIENT IS A DEPENDENT CHILD OVER THE AGE OF 18, PLEASE COMPLETE THE FOLLOWING:

1. AGE OF THE CHILD _____
2. IS HE/SHE MARRIED? ☐ YES ☐ NO
3. IS HE/SHE EMPLOYED FULL-TIME? ☐ YES ☐ NO
4. IS HE/SHE IN FULL-TIME ATTENDANCE AT SCHOOL, COLLEGE, OR UNIVERSITY? ☐ YES ☐ NO
5. IS HE/SHE PHYSICALLY OR MENTALLY INCAPACITATED AND DEPENDENT ON YOU FOR SUPPORT? ☐ YES ☐ NO

## 3 - DENTIST/DENTURIST — Examination and Treatment Record

BLUE CROSS USE ONLY

| SERVICES PERFORMED DAY MON YEAR | TOOTH CODE INT.NO. | PROCEDURE NUMBER | SPECIFIC SURFACES FILLED | SERVICE MATERIAL | QTY. OR UNITS | AMOUNT BILLED | BLUE CROSS PAYS | REJECT REASON |
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I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE ARE CORRECT AND REPRESENT THOSE RENDERED TO THE PATIENT NAMED.

DENTIST'S/DENTURIST'S SIGNATURE _____ DATE: _____





MBC-1018_JUNE_2008

## AUTHORIZATION AND CONSENT

I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by Manitoba Blue Cross and/or Blue Cross Life Insurance Company of Canada may be collected, used, or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, to develop and recommend suitable products and services to me, and to manage the Company's business.

Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These include other Blue Cross organizations, licensed physicians and/or any other healthcare professionals or institutions, health and life insurers, government and regulatory authorities, the certificate holder of any policy under which I am a participant and other third parties when required to administer the benefits outlined in my policy or the group policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding Blue Cross' privacy policies I can contact Blue Cross at 775-0151 or toll free at 1-800-873-2583 or www.mb.bluecross.ca should I have questions as to the collection, use or disclosure of my personal information.

I authorize Blue Cross to collect, use and disclose my personal information as described above.