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.

PATIENT

IS TREATMENT REQUIRED AS A RESULT OF ACCIDENT?

☐ YES ☐ NO IF YES, GIVE DETAILS

EMPLOYEE

ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER INSURANCE OR DENTAL PLAN?

☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING

PERSON INSURED UNDER OTHER PLAN

BIRTH DATE / / DAY MONTH YEAR

EMPLOYER

EMPLOYER'S INSURANCE COMPANY

POLICY OR CONTRACT NUMBER

EMPLOYEE

CONTRACT NUMBER | GROUP NUMBER

SURNAME | FIRST NAME

ADDRESS | BIRTH DATE 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 | BIRTH DATE DAY MON. YEAR | RELATIONSHIP TO EMPLOYEE ☐ 1 SELF ☐ 2 SPOUSE ☐ 3 DEPENDENT

PHONE HOME OFFICE

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 DENTIST/DENTURIST? ☐ YES ☐ NO

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN)_____ PLEASE SIGN HERE

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**

SERVICES PERFOR. DAY	MON.	YR.	TOOTH CODE INT.NO.	PROCEDURE NUMBER	SPECIFIC SURFACES FILLED	SERVICE MATERIAL	QTY. OR UNITS	AMOUNT BILLED	BLUE CROSS USE ONLY: BLUE CROSS PAYS	REJECT REASON
									$	

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE ARE CORRECT AND REPRESENT THOSE RENDERED TO THE PATIENT NAMED.

DENTIST'S/DENTURIST'S SIGNATURE _____ DATE:

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P.O. BOX 1046, WINNIPEG, MANITOBA R3C 2X7 PHONE 775-0151 OR TOLL FREE WITHIN MANITOBA 1-800-USE-BLUE (1-800-873-2583)