MEDAVIE BLUE CROSS™

P.O. BOX 3300, STATION "B", MONTREAL (QUEBEC) H3B 4Y5
TEL.: 514-286-8430

DENTAL CARE CLAIM FORM

FOR DENTIST'S USE

THE DENTAL SERVICES HAVE BEEN RENDERED ☐ ARE FORESEEN (PREDETERMINATION) ☐

DENTIST

Name of **Dentist** _____

Address _____

City _____ Province _____

Postal Code _____ Telephone _____

LICENSE No. _____

PATIENT

Name of **Patient** _____

Given Name(s) _____

Address _____ Apt. _____

City _____ Province _____

Postal Code _____ Telephone _____

DATE OF SERVICE D	M	Y	INTL TOOTH CODE	PROCEDURE CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

This is an accurate statement of services performed and fees charged.

_____
Dentist's Signature

TOTAL FEE SUBMITTED

Date _____ Day _____ Month _____ Year

For dentist's use only for additional information re: diagnosis, procedures or complications, and special considerations.

AUTHORIZATION

I understand that I am financially responsible to my dentist for the entire cost of the treatment. I authorize release of the information contained in this claim form to my insurance company or its agents.

_____
Signature of Patient (or parent / guardian)

FOR SUBSCRIBER'S USE

* Your group and certificate numbers are ESSENTIAL for the processing of your claim;
* The signatures requested are COMPULSORY.

Name _____

Given Name(s) _____

Date of Birth _____

Group No. _____

Certificate No. _____

Address _____ Apt. _____

City _____ Province _____

Postal Code _____

Telephone: Home _____

Office _____

Patient's Relationship
☐ Spouse ☐ Son ☐ Daughter

Date of Birth _____
Day Month Year

Children 18 or 21 and over (according to your contract) ☐ Student ☐ Handicapped

If student, name of institution attended:

_____

Session

_____

PAYMENT

Should the refund be paid to the dentist? ☐ Yes ☐ No Subscriber's Initials _____

Are you covered by another dental care insurance? ☐ Yes ☐ No Is your spouse covered by another dental insurance? ☐ Yes ☐ No

If yes, insurer's name: _____

N.B.: The spouse who is covered by another dental care plan must first submit his(her) claim to his(her) insurer. Afterwards, provide Medavie Blue Cross with a detailed account of the benefits paid and a copy of the form submitted to his(her) insurer. Furthermore, claims for children must be submitted to the insurer of the parent (father or mother) whose birthday occurs first in the calendar year.

Was treatment rendered as the result of an accident? ☐ Yes ☐ No

If yes, date of the accident: _____ Place and circumstances: _____

If denture, crown or bridge, is this the initial placement? ☐ Yes ☐ No

If yes, date of extraction: _____ Made by Dr _____

If no, date of prior placement: _____ Made by Dr _____

Reason for replacement: _____

I certify that the information given is true and complete and I authorize the release of any information or records requested in respect of this claim to the Insurer.

Date: _____ Subscriber's Signature : _____

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL.