PACIFIC BLUE CROSS™

DO NOT WRITE IN THIS SPACE

DENTAL CLAIM FORM

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | www.pac.bluecross.ca

Please enclose all supporting documentation, if necessary.
See page 2 for important information about preparing your dental claim.

PART 1 — PATIENT INFORMATION

Patient's first name

Patient's last name

Street address

City | Province | Postal code

Additional information, diagnosis, procedures or special considerations

PART 2 — PROVIDER INFORMATION

Unique number | Office number | Spec. | Patient's office account number

Provider's name

Street address

City

Province | Postal code | Phone number (10 digits)

Provider/authorized signature (or attach receipts showing payment for services)
X

Date (mm-dd-yyyy)

PART 3 — PLAN MEMBER

Send payment to:
☐ Plan member
☐ Provider — I hereby assign my benefits payable from this claim to the named dentist and authorize payment directly to him/her.

Member's signature
X

Date (mm-dd-yyyy)

PART 4 — CLAIM INFORMATION

SERVICE DATE	PROCEDURE CODE	SERVICE DESCRIPTION	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LAB CHARGE	TOTAL CHARGES
(mm-dd-yyyy)					$	$	$
(mm-dd-yyyy)					$	$	$
(mm-dd-yyyy)					$	$	$
(mm-dd-yyyy)					$	$	$
(mm-dd-yyyy)					$	$	$
(mm-dd-yyyy)					$	$	$
(mm-dd-yyyy)					$	$	$
					GRAND TOTAL		$ 0

PART 5 — EMPLOYEE/PLAN MEMBER INFORMATION

Policy number | ID number | Employer's name | Daytime phone number (10 digits)

Employee/Plan member's first name | Employee/Plan member's last name | Employee/Plan member's birthdate (mm-dd-yyyy)

PART 6 — PATIENT INFORMATION

Relationship to Plan member: ☐ Self ☐ Spouse ☐ Child | Patient's birthdate (mm-dd-yyyy)

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 my dental 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 the communication of information related to the coverage of services described in this form to the named dental provider.

Patient's signature (or parent/guardian)
X

Date (mm-dd-yyyy)

PART 7 — OTHER INSURANCE COVERAGE: Complete this section if these services are covered by any other dental plan

Name of person with other coverage | Birthdate of other coverage holder (mm-dd-yyyy)

Policy number | ID number | Employment status ☐ Full-time ☐ Part-time ☐ Retiree | Coverage type ☐ Single ☐ Family | Name of insuring company

Effective date (mm-dd-yyyy) | Termination date (mm-dd-yyyy) | Is any treatment required as a result of an accident? ☐ Yes ☐ No (If yes, provide details separately.)