QUÉBEC BLUE CROSS®

# DENTAL CARE CLAIM FORM

P.O. 1630, Station "B", Montreal (Quebec) H3B 3L3
Tel.: (514) 286-6006 • 1 800 363-3958

**FOR DENTIST'S USE**

The dental services have been rendered ☐ are foreseen (predetermination) ☐

Name of **dentist** _____

Address _____

City _____ Province _____

Postal code _____ Telephone _____

LICENSE No. _____

**Patient's** name _____

Given name(s) _____

Address _____ Apt. _____

City _____ Province _____

Postal code _____ Telephone _____

| Date of service D | M | Y | Int. tooth code | Procedure code | Tooth surfaces | Dentist's fee | Laboratory charges | Total charges |
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This is an accurate statement of services performed and fees charged.

_____
Dentist's signature

**Total submitted fee**

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 care 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 Blue Cross Group Benefits 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 : _____