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:

MBC 1018-75M-05/2009

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

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 at 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.