BLUE CROSS™ NEXUS NETWORK

DENTAL CLAIM FORM

PART 1 DENTIST

UNIQUE NO. | SPEC | PATIENT'S OFFICE ACCOUNT NO.

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.

PATIENT

FIRST NAME _____ LAST NAME _____

ADDRESS _____ APT. _____

CITY _____ PROV. _____

POSTAL CODE _____

DENTIST

PHONE NO. _____

SIGNATURE OF MEMBER

FOR DENTIST'S USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION.

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 DENTIST 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 DENTIST.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

DUPLICATE FORM ☐

OFFICE VERIFICATION

DATE OF SERVICE DD	MM	YYYY	PROCEDURE CODE	INTL TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LAB OR EXPENSE CHARGE	L OR E	TOTAL CHARGES

This is an accurate statement of services performed and the total fee due and payable, E & OE.

Total Fee Submitted:

PART 2 - CARDHOLDER INFORMATION

ID Number: _____ Policy Number: _____ Date of Birth: _____ DD/MM/YYYY

Member Last Name: _____ Member First Name: _____

PART 3 - PATIENT INFORMATION

Date of Birth: _____ DD/MM/YYYY Relationship to Member: _____

Are any dental benefits or services provided under any other group insurance or dental plan, WCB or Gov't plan?

☐ No If applicable, provide the termination date: _____ DD/MM/YYYY

☐ Yes If Yes, complete the following: Name of other Insurer: _____

Policy Number: _____ Spouse Date of Birth: _____ DD/MM/YYYY

Is any treatment required as the result of an accident? ☐ No ☐ Yes
If yes, provide date and details separately.

_____

If treatment includes denture, crown or bridge, is this an initial placement? If no, provide date of prior placement and reason for replacement. ☐ No ☐ Yes

_____

PART 4 - HEALTH CARE SPENDING ACCOUNT

If benefits are available under more than one plan, we encourage you to submit your claim to your other plan, before using your Health Care Spending Account (HCSA).

Select one of the following:

☐ Process this claim under my dental benefit first, then any unpaid balance under my HCSA.
☐ Process this claim under my HCSA ONLY. Do NOT process under my dental benefits.
☐ Do NOT use my HCSA for this claim.

If a selection at the left is not completed, this claim will only be processed against your dental benefits.

PART 5 - MEMBER STATEMENT

I authorize the release of any information or records requested in respect of this claim to the insurer/plan administrator and certify that the information given is true, correct and complete to the best of my knowledge. Claiming benefits implies consent to Blue Cross privacy protection practices.

All medical expenses must be claimed through your provincial and group insurance plan before payment can be made from a Health Care Spending Account. I confirm that benefits under this plan, any government program or alternate group plan (ie. spouse's/parnter's coverage) have been accessed. **I understand that should any tax consequences arise from reimbursement of these expenses, I am responsible for payment of such taxes.** If claiming expenses for an uninsured dependent under your health/dental plan, I, the undersigned, accept full responsibility that this dependent qualified under the Canadian Federal Income Tax Act as an eligible dependent.

Member Signature: _____ Name: (please print): _____ Date: _____

ADDRESSES

Atlantic Canada*
PO Box 220
644 Main St
Moncton NB
E1C 8L3

Quebec*
PO Box 3300,
Postal Stn B
Montreal QC
H3B 4Y5

Ontario*
PO Box 2000, Suite 1200
185 The West Mall
Etobicoke ON
M9C 5P1

Manitoba*
PO Box 1046
Winnipeg MB
R3C 2X7

Saskatchewan*
PO Box 4030
516 2nd Avenue N
Saskatoon SK
S7K 3T2

Alberta*
PO Box 2318 STN Main
Edmonton AB
T5J 0L8

British Columbia*
PO Box 7000
Vancouver BC
V6B 4E1

** Each plan is an independent licensee of the Canadian Association of Blue Cross Plans.*

INQUIRIES: 1-888-691-8898

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