MEDAVIE BLUE CROSS™

EXTENDED HEALTH BENEFIT INJURIES REPORT – FOR ACCIDENTAL DENTAL

SECTION 1: TO BE COMPLETED AND SIGNED BY THE CARDHOLDER

CARDHOLDER INFORMATION

Full Name: _____

ID Number: _____ Policy Number: _____

INJURED PERSON

Full Name: _____

Address: _____

Date of Birth: _____

ACCIDENT DETAILS

Date of Accident: _____ Province/Country where Accident Occured: _____

Description of Accident (how, what, etc): _____

_____

OTHER COVERAGE (Health & Dental)

Will another insurance policy cover any health and/or dental expenses as a result of this accident? ❑ Yes ❑ No
If yes, please provide the following information:

Name of other Insurer: _____ Policy Number: _____

I hereby certify that the information stated on this document is true, correct and complete to the best of my knowledge.

Cardholder Signature: _____ Date: _____

SECTION 2: TO BE COMPLETED AND SIGNED BY THE DENTAL PROVIDER

DENTAL INFORMATION

PRE-TRAUMA (prior to the accident occurring) as well as **POST-TRAUMA** (taken at the initial visit regarding the accident)

x-rays of all the affected teeth are required for assessment of All Accidental Dental cases

CHECK Tooth/Teeth injured in this accident (using the FDI numbering system)

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

55	54	53	52	51				61	62	63	64	65			
85	84	83	82	81				71	72	73	74	75			

Were the injured tooth/teeth whole /sound teeth? ❑ Yes ❑ No
(A sound natural tooth is a tooth that is whole, free of decay, periodontal disease or other conditions and is not in need of treatment for any reason other than the accidental injury)

List the injured teeth that previously had restorations? _____

List the injured teeth that previously had crowns or fixed bridge? _____

List the injured teeth that previously had root canal treatment? _____

DENTIST INFORMATION

Treating Dentist Name: _____ Unique Number: _____

Address: _____

Telephone Number: _____ Fax Number: _____

Office Verification / Signature: _____

PLEASE MANUALLY SUBMIT ALL ACCIDENTAL DENTAL CLAIMS AND TREATMENT PLANS TO:

MEDAVIE BLUE CROSS
Att: Accidental Dental Unit, 644 Main Street, PO Box 220, Moncton, NB E1C 8L3
Call Inquiries: 1-800-667-4511
Email: inquiry@medavie.bluecross.ca Att : Accidental Dental
Member Fax: 506-867-4651 Att: Accidental Dental Provider Fax: 506-869-9669 Att: Accidental Dental