SASKATCHEWAN BLUE CROSS®
516 – 2nd Avenue N P.O. BOX 4030 SASKATOON, SK. S7K 3T2
Tel: (306) 244-2662 Fax: (306) 652-5751

STANDARD GROUP DENTAL CLAIM FORM

PART 1 - DENTIST

PATIENT

LAST NAME | GIVEN NAME

ADDRESS | APT.

CITY | PROV. | POSTAL CODE

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

DENTIST

PHONE NO.

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

SIGNATURE OF EMPLOYEE

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.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

DUPLICATE FORM ❑ ESTIMATE ❑

OFFICE VERIFICATION

DATE OF SERVICE			INTL. TOOTH CODE	PRO CEDURE CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES
Da	Mo	Yr						

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND
THE TOTAL FEE DUE AND PAYABLE, E & OE. **TOTAL FEE SUBMITTED**

****IMPORTANT INFORMATION****

PRE-TREATMENT PLAN: If your dentist has recommended crowns and/or bridgework, or any other dental expense over $500.00 (per patient), please have your dentist complete a pre-treatment plan and submit it, along with your dental x-rays, to Saskatchewan Blue Cross before treatment begins.

CO-ORDINATION OF BENEFITS: A method used by the insurance industry to determine the order of paying benefits when the spouse and children are covered under more than one group insurance plan. For example: A spouse who is covered under his/her employer's plan must submit to that employer's plan first, and claims for children must be submitted under the plan of the parent with the earlier month then day of birth in the calendar year.

MAILING INSTRUCTIONS: Mail completed form to the address listed above.

PART 2 – EMPLOYEE INFORMATION

Employee ID _____ Policy Number _____

Name of Employer _____

Employee's Name _____

Date of Birth _____ / _____ / _____ (Year) (Month) (Day) Sex ❑ M ❑ F

Address _____ (Street/Apt/RR #)

(City) (Province) (Postal Code)

(Phone Number - Home) (Phone Number – Work)

PART 3 – PATIENT INFORMATION

1. Relationship to Employee: ❑ SELF ❑ SPOUSE ❑ CHILD

   Date of Birth _____ / _____ / _____ (Year) (Month) (Day)

   Children Only, Check If: Full-Time University or College Student ❑ Disabled ❑

2. Is this a replacement of a crown, bridge or denture? Yes ❑ No ❑

   If Yes, indicate date of previous replacement _____ / _____ / _____ (Year) (Month) (Day)

   Reason for replacement _____

3. Is treatment required for orthodontic purposes? Yes ❑ No ❑

PART 4 - CO-ORDINATION OF BENEFIT AND ACCIDENT INFORMATION

1. Are any of the expenses being claimed covered by another group insurance plan? *If Yes, complete the following information about the person who is the* ***EMPLOYEE UNDER THE OTHER PLAN.*** ❑ Yes ❑ No

   Name of Other Employee _____

   Identification Number _____

   Date of Birth _____ / _____ / _____ (Year) (Month) (Day)

   Insurance Company's Name _____ Policy # _____

2. If your dental coverage under another group insurance plan has been cancelled, please give the cancellation date: _____ / _____ / _____ (Year) (Month) (Day)

3. Is any treatment required as a result of an accidental injury? Yes ❑ No ❑

   If Yes, did the accidental injury happen at work? Yes ❑ No ❑

   Date of accidental injury _____ / _____ / _____ (Year) (Month) (Day)

   Please provide a letter explaining the details of the accidental injury, and indicating if another party is liable.

PART 5 – AUTHORIZATION

I certify that the information given on this form is true, correct and complete to the best of my knowledge. I authorize the release by any health care provider, Saskatchewan Blue Cross or any of its agents, of any information necessary for the administration of this claim or my group plan. A photocopy of this authorization is as valid as the original.

EMPLOYEE'S SIGNATURE ✘ DATE _____ / _____ / _____ (Year) (Month) (Day)

The intentional falsification, misrepresentation or omission of information on or relating to this claim constitutes fraud.

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