

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | pac.bluecross.ca

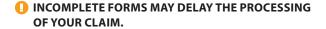
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		pporting docun ant information			al claim.								
PART 1 —	PATIENT INF	PART 2 — PROVIDER INFORMATION						P	PART 3 — PLAN MEMBER				
Patient's first name		Unique number Office		number Spec. Pat		atient's office account number		Send payment to:					
Patient's last name				Provider's name						- □ Plan member □ Provider — I hereby assign			
Street address		Street address						my benefits payable from this claim to the named dentist and					
City		City						authorize payment directly to					
Additional informat	tion, diagnosis, procec	Province Postal code Phone number (10 digits)						him/her.					
				Provider/authorize	d signature (or	attach rece	ipts showin	ng payme	nt for services)	Mei	mber's signature		
		X Date (mm-dd-yyyy)						X					
				Date (IIIII-dd-yyyy))					Dat	e (mm-dd-yyyy)		
PART 4 —	CLAIM INFO	RMATION					1					,	
SERVICE DATE	PROCEDUR CODE	E SER	SERVICE DESCR					TH ACES	DENTIST'S FEE		LAB CHARGE	TOTAL CHARGES	;
(mm-dd-yyyy)									\$		\$	\$	
(mm-dd-yyyy)									\$		\$	\$	
(mm-dd-yyyy)									\$		\$	\$	
(mm-dd-yyyy)									\$		\$	\$	
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(mm-dd-yyyy)									\$		\$	\$	
(mm-dd-yyyy)									\$		\$	\$	
										GI	RAND TOTAL	\$	
PART 5 —	EMPLOYEE/I	PLAN MEMBE	R INFORM <i>i</i>	ATION									
Policy number		Employer's name							Day	time phone number (10	digits		
Employee/Plan member's first name				Employee/Plan member's last name							Employee/Plan mer	nber's birthdate (mm-dd	-уууу
PART 6 —	PATIENT INF	ORMATION											
Relationship	to Plan memb	er: □ Self □ Sp	ouse □ Chil	Patient's birthdat	te (mm-dd-yyy)	y)							
		sted in this clair					plan be	nefits.				ally responsible arged to me for	
services rend	lered. I authori		information	contained in t	this claim f	form to	•		ompany/pla	ın a	dministrator. I	also authorize th	
Patient's signature	(or parent/guardian)								Da	ate (m	nm-dd-yyyy)		
	OTHER INSU	RANCE COVE	RAGE: Com	plete this se	ection if t	hese s	ervices	s are	covered by	an	y other dent	al plan	
Name of person wit	th other coverage										Birthdate of other c	overage holder (mm-dd-	уууу
Policy number		ID number		Employment status Full-time	□ Part-time	= □ Ret		overage t	_{ype} e □ Family	Nam	 ne of insuring compai	ny	
Effective date (mm-	-dd-yyyy) Termin	l ation date (mm-dd-yyy)	ls any tre						-	If ye	es, provide det	ails separately.)	

Place your receipts loose and flat in the envelope — no staples, paperclips or tape. Also no cashier or Interac receipts.

TIPS FOR PREPARING YOUR DENTAL CLAIM

If your dentist is not able to submit your claim directly to Pacific Blue Cross, you can complete your dental claim form. Follow these guidelines to ensure all required information is included to prevent payment delays.

- 1. Required information:
 - Plan member's full name
 - Patient's full name, relationship to member and birthdate
 - Plan member's policy and ID numbers
 - Plan member's mailing address if claim is pay-member
 - Dentist's signature or authorization (or attached receipts)
 - Dentist's name and unique number
 - Indicate if Pacific Blue Cross should reimburse the member or the dentist
 - Information about additional dental coverage (with Pacific Blue Cross or with another carrier)
 - If you are claiming for the balance not paid by the other insurance company, include photocopies of your receipts and their payment statement
- 2. We also need information about the dental services that were performed. Ask your dentist to complete *Part 4 Claim Information* and include:
 - Service date
 - Procedure code and/or service description
 - Tooth codes and surfaces (if applicable)
 - Fees charged







Pacific Blue Cross PO Box 7000, Vancouver, BC V6B 4E1

OROP IT OFF 4250 Canada Way Burnaby, BC V5G 4W6

QUESTIONS?

604 419-2000 Toll-free: 1 877 PAC-BLUE

pac.bluecross.ca

HOW TO SUBMIT YOUR DENTAL CLAIM FORM

- Ask your dentist to submit your claim
- Mail your claim to Pacific Blue Cross
- Drop off your claim to the Pacific Blue Cross office

HOW TO SUBMIT A CLAIM FOR ORTHODONTICS

When submitting an orthodontic claims, submit a treatment plan before the treatment begins and submit receipts following the procedure.

SUBMIT A TREATMENT PLAN

At the start of the orthodontic treatment, the dentist or orthodontist will prepare a written outline of the proposed treatment. This is called a treatment plan. We need a copy of the treatment plan before we can reimburse an orthodontic claim.

When your orthodontist gives you the treatment plan, send it to Pacific Blue Cross. Make sure to include:

- Patient's full name, relationship to member and birthdate
- Plan member's policy and ID numbers
- Information about additional dental coverage (with Pacific Blue Cross or with another carrier)

SUBMIT RECEIPTS (OR CLAIM FORMS)

Make sure to include:

- Plan member's full name
- Patient's full name, relationship to member and birthdate
- Plan member's policy and ID numbers
- Plan member's mailing address
- Information about additional dental coverage (with Pacific Blue Cross or with another carrier)
- You can submit orthodontic claims on CARESnet, including initial and monthly fees.