



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

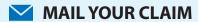
Please enclose all supporting documentation, if necessary. See page 2 for important information about preparing your dental claim. **PART 1 — PATIENT INFORMATION PROVIDER INFORMATION** PART 3 — PLAN MEMBER PART 2 -Patient's first name Unique number Office number | Spec. Patient's office account number Send payment to: ☐ Plan member Patient's last name Provider's name ☐ Provider — I hereby assign my benefits payable from this Street address Street address claim to the named dentist and authorize payment directly to City Province Postal code City him/her. Province Additional information, diagnosis, procedures or special considerations Postal code Phone number (10 digits) Provider/authorized signature (or attach receipts showing payment for services) Member's signature Date (mm-dd-yyyy) Date (mm-dd-yyyy) PART 4 — CLAIM INFORMATION **PROCEDURE** INTL. TOOTH **DENTIST'S SERVICE TOOTH LAB TOTAL SERVICE DESCRIPTION** CODE CODE **SURFACES CHARGES** DATE FEE **CHARGE** (mm-dd-yyyy) \$ \$ \$ (mm-dd-yyyy) \$ \$ \$ (mm-dd-yyyy) \$ \$ \$ (mm-dd-yyyy) \$ \$ \$ (mm-dd-yyyy) Ś Ś Ś (mm-dd-yyyy) \$ \$ \$ (mm-dd-yyyy) \$ \$ \$ **GRAND TOTAL** \$ **EMPLOYEE/PLAN MEMBER INFORMATION** PART 5 -Policy number Employer's name Daytime phone number (10 digits) Employee/Plan member's first name Employee/Plan member's last name Employee/Plan member's birthdate (mm-dd-yyyy) **PART 6 — PATIENT INFORMATION** Patient's birthdate (mm-dd-yyyy) Relationship to Plan member: ☐ Self ☐ Spouse ☐ Child 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 dental provider 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 dental provider. Patient's signature (or parent/guardian) Date (mm-dd-vvvv) PART 7 — OTHER INSURANCE COVERAGE: Complete this section if these services are covered by any other dental plan Name of person with other coverage Birthdate of other coverage holder (mm-dd-yyyy) Policy number ID number **Employment status** Coverage type Name of insuring company ☐ Full-time ☐ Part-time ☐ Retiree ☐ Single ☐ Family Effective date (mm-dd-yyyy) Termination date (mm-dd-yyyy) Is any treatment required as a result of an accident? ☐ Yes ☐ No (If yes, provide details separately.)

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
- INCOMPLETE FORMS MAY DELAY THE PROCESSING OF YOUR CLAIM.





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

DROP IT OFF4250 Canada WayBurnaby, BC V5G 4W6

QUESTIONS?

604 419-2300

Toll-free: 1 888 275-4672

www.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)
- including initial and monthly fees.



Explore CARESnet at

www.pac.bluecross.ca

- Create your account.
- Submit online claims.
- Save provider information.
- Sign up for direct deposit payments.
- Check your dependent coverage.
- Track health expenses and limits.
- Access My Good Health®, an online healthy lifestyle resource exclusive to members of Pacific Blue Cross.
- Send a copy of your ID card to your mobile device.