



P.O. BOX 1046, WINNIPEG, MANITOBA R3C 2X7
 PHONE TOLL FREE WITHIN MANITOBA AT 1-800-USE-BLUE (1-800-873-2583)
 FEES FOR THE COMPLETION OF THIS FORM ARE NOT ELIGIBLE.

EXTENDED HEALTH BENEFITS CLAIM FORM

For Dental Accident Only

GROUP	BLUE CROSS CONTRACT NO.	SURNAME	PATIENT FIRST NAME	BIRTH YEAR
HAS YOUR ADDRESS CHANGED IN PAST YEAR <input type="checkbox"/> YES <input type="checkbox"/> NO				
STREET, P.O. BOX NO.		CITY/TOWN	VILLAGE	POSTAL CODE

ACCIDENT DATE: _____ ACCIDENT LOCATION: _____ COMPLETE ACCIDENT DETAILS: _____	ARE ANY BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER INSURANCE? DENTAL PLAN <input type="checkbox"/> YES <input type="checkbox"/> NO HEALTH PLAN <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, COMPLETE THE FOLLOWING: PERSON INSURED UNDER OTHER PLAN: _____ EMPLOYER: _____ EMPLOYER'S INSURANCE CO.: _____ POLICY OR CONTRACT NUMBER: _____
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REPORT OF ATTENDING DENTIST

D E N T I S T	DATE PATIENT FIRST TREATED FOR INJURIES RESULTING FROM THIS ACCIDENT: _____ DATE OF LAST TREATMENT: _____
	DESCRIBE EXACT NATURE, LOCATION AND EXTENT OF ALL INJURIES SUSTAINED: _____ _____ _____ DATE: _____, 20 _____
	DENTIST SIGNATURE: _____ DATE: _____, 20 _____
	NAME AND ADDRESS OF DENTAL OFFICE:
	NAME: _____ ADDRESS: _____

DENTIST REPORT

PRE-TREATMENT AUTHORIZATION IS REQUIRED ON DENTAL WORK IN EXCESS OF \$500.00
 HAS TREATMENT BEEN COMPLETED? YES NO PLEASE COMPLETE FUTURE TREATMENT BELOW.

D E N T I S T	SERVICES PERFORMED			TOOTH CODE	PROCEDURE NUMBER	AMOUNT	BLUE CROSS ONLY	
	DAY	MON.	YR.				M.D.A.	AMOUNT
I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE ARE CORRECT AND REPRESENT THOSE RENDERED TO THE PATIENT NAMED.						TOTAL		
DENTIST'S SIGNATURE _____						DATE: _____		

FUTURE TREATMENT – PLEASE INDICATE ANY FUTURE WORK WHICH MAY BE REQUIRED AS A RESULT OF THIS ACCIDENT.

TOOTH	PROCEDURE	YEAR SERVICE TO BE PERFORMED	CURRENT COST (APPROX.)	REMARKS

IS PAYMENT TO BE MADE TO THE PROVIDER OF SERVICE? <input type="checkbox"/> YES <input type="checkbox"/> NO I HEREBY ASSIGN BENEFITS TO THE FOLLOWING PROVIDER: NAME _____ ADDRESS _____ _____ POSTAL CODE _____	I CERTIFY THAT I AM AWARE OF AND HAVE READ THE AUTHORIZATION AND CONSENT ON THE REVERSE SIDE OF THIS CLAIM FORM. I UNDERSTAND THAT THE CHARGES LISTED MAY NOT BE COVERED BY OR MAY EXCEED MY POLICY BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE ABOVE PROVIDER FOR THE ENTIRE COST OF THE TREATMENT. SUBSCRIBER'S SIGNATURE _____ (PLEASE SIGN HERE) PHONE RES: _____ BUS.: _____
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