

Dental Claim Form



Members 604 419-2300 Toll Free 1-888-275-4672

Mailing Address: PO Box 7000
Vancouver, BC
V6B 4E1

Street Address: 4250 Canada Way
Burnaby, BC

- New Claim** **Preauthorization**
 Resubmission **Adjustment**

P A T I E N T	First Name		Last Name	
	Street Address			
	City		Province	
	Postal Code			
	Patient's Office Account #		Claim #	

(Part A)

P R O V I D E R	PBC Payment #	
	First Name	Last Name
	Street Address	
	City	Province
	Postal Code	Phone Number
	Provider/Authorized Signature (or attach the receipt showing payment for these services)	

Additional Information

Send payment to:

Provider **Member**

Date of Service	Procedure Code	Description of Service	Tooth Code	Tooth Surfaces	Dentist's Fee	Lab Fee	Total Fee	For PBC Use Only

Employee/Plan Member/Subscriber

Group # D	Employer Name		
Social Insurance or ID number	Employee First Name	Last Name	Employee Birth Date (yy/mm/dd)

Patient (Part B)

The dental office is required to have the patient's signature on file.

Dependent #	Patient Birth Date (yy/mm/dd)
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Is any treatment required as a result of an accident?
 Yes No
 (If yes, provide date & details separately)

Other Coverage - Complete this section if these services are covered by any other dental plan.

Name of insuring agency or carrier	_____ % Plan A (Basic)	If PBC, please indicate: Group # D
Name of other coverage holder		
Birth date of other coverage holder (yy/mm/dd)	_____ % Plan C (Ortho)	Social Insurance or ID number