

## How to Fill in this Dental Claim Form

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

Required information about patient:

- Patient's full name
- Patient's dependent number and birth date
- Member's group and ID numbers
- Member's mailing address, if claim is pay-member
- Dentist's signature or authorization (or attach receipt)
- Dentist's name and PBC ID number
- Indicate if PBC should reimburse the member or the dentist
- Information about additional dental coverage (with Pacific Blue Cross or with another carrier)

We also need information about the dental services that were performed. Ask your dentist to complete this section and include:

- Date of Service
- Procedure code or description of service
- Tooth numbers and surfaces (if applicable)
- Fee charged

## How You Can Submit this Dental Claim Form

- Ask your dentist to send in your claim
- Mail your claim to: Pacific Blue Cross  
PO Box 7000, Vancouver BC V6B 4E1
- Drop off your claim at 4250 Canada Way, Burnaby (we're at the corner of Canada Way and Gilmore)

## How to Submit a Claim for Orthodontics

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

### 1. 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 completed treatment plan form, forward it to PBC. Make sure to include:

- Patient's full name
- Patient's dependent number and birth date
- The member's group and ID numbers
- Information about additional dental coverage (with Pacific Blue Cross or with another carrier)

### 2. Submit receipts (or claim forms)

Make sure to include:

- Patient's full name
- Patient's dependent number and birth date
- The member's group and ID numbers
- Member's mailing address
- Information about additional dental coverage (with Pacific Blue Cross or with another carrier)



Secure, 24/7 online access to benefit and claims information for members



- View a summary of your EHC or dental plan
- See Health Spending Account balances (Available if you have a Health Spending Account as part of your benefit plan)
- Inquire about your claim history
- Download claim forms
- Enrol for direct deposit and online claims statements

[www.pac.bluecross.ca](http://www.pac.bluecross.ca)

Providers: 604 419-2236

Toll-free: 1 888 419-2236

Mailing address:  
PO Box 7000  
Vancouver BC V6B 4E1

Street address:  
4250 Canada Way  
Burnaby BC

New claim

Pre-authorization

Re-submission

Adjustment

## Patient – Part A

|                                 |              |
|---------------------------------|--------------|
| First name                      | Last name    |
| Street address                  |              |
| City                            |              |
| Province                        | Postal code  |
| Patient's office account number | Claim number |

Additional information

## Provider

|   |                           |
|---|---------------------------|
| PBC provider payment number   |                           |
| Provider first name   | Last name                 |
| Street address  |                           |
| City  | Province                  |
| Postal code   | Phone number (ten digits) |
| Provider/authorized signature (or attach receipts showing payment for services) |                           |

Send payment to:  Provider  Member

| Date of Service<br>yyyy/mm/dd | Procedure<br>Code | Description of Service | Tooth<br>Code | Tooth<br>Surfaces | Professional<br>Fee | Lab Fee | Total Fee | PBC Use |
|-------------------------------|-------------------|------------------------|---------------|-------------------|---------------------|---------|-----------|---------|
|                               |                   |                        |               |                   |                     |         |           |         |
|                               |                   |                        |               |                   |                     |         |           |         |
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|                               |                   |                        |               |                   |                     |         |           |         |
|                               |                   |                        |               |                   |                     |         |           |         |

## Employee/Member

|               |                     |           |                                  |
|---------------|---------------------|-----------|----------------------------------|
| Policy number | Employer name       |           |                                  |
| ID number     | Employee first name | Last name | Employee birth date (yyyy/mm/dd) |

## Patient – Part B

*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.*

Signature of patient (or parent/guardian)

|                  |                                 |
|------------------|---------------------------------|
| Dependent number | Patient birth date (yyyy/mm/dd) |
|------------------|---------------------------------|

## Other Coverage

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

|  |                                      |
|--|--------------------------------------|
| Name of insuring agency or carrier   | Plan A – Basic<br>%                  |
| Name of other coverage holder  | Plan B – Major<br>%                  |
| Birth date of other coverage holder (yyyy/mm/dd)   | Plan C – Ortho<br>%                  |
| Policy number  | ID number or Social Insurance Number |
| Is any treatment required as a result of an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, provide date and details separately. |                                      |