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. This will 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. Required information about service:

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

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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 indicate:

- 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 indicate:

- 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)

CARESNET™

Secure online access to benefit information for Pacific Blue Cross members.
www.pac.bluecross.ca

How to 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)

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Dental Claim Form

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**

☐ **Resubmission** ☐ **Adjustment**

PATIENT (Part A)

First Name | Last Name

Street Address

City | Province

Postal Code

Patient's Office Account # | Claim #

PROVIDER

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 Year Month Day	Procedure Code	Description of Service	Tooth Code	Tooth Surfaces	Professional 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 (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 (parent/guardian)

Dependent # | Patient Birth Date (yyyy mm dd)

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

Name of other coverage holder

Birth date of other coverage holder (yyyy mm dd)

_____ % Plan A (Basic)

_____ % Plan B (Major)

_____ % Plan C (Ortho)

If PBC, please indicate:
Group #
D

Social Insurance or ID number