PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

STUDENTCARE

THE GRADUATE STUDENT SOCIETY OF SFU DENTAL CLAIM FORM

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

Please enclose all supporting documentation, if necessary.
For information, visit studentcare.ca or call 1 866 369-8795.

PART 1 — PATIENT INFORMATION

Patient's first name

Patient's last name

Street address

City | Province | Postal code

Additional information, diagnosis, procedures or special considerations

PART 2 — PROVIDER INFORMATION

Unique number | Office number | Spec. | Patient's office account number

Provider's name

Street address

City

Province | Postal code | Phone number (10 digits)

Provider/authorized signature (or attach receipts showing payment for services)
X

Date (mm-dd-yyyy)

PART 3 — STUDENT

Send payment to:
☐ Student
☐ Provider — I hereby assign my benefits payable from this claim to the named dentist and authorize payment directly to him/her.

Student's signature
X

Date (mm-dd-yyyy)

PART 4 — CLAIM INFORMATION

SERVICE DATE	PROCEDURE CODE	SERVICE DESCRIPTION	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LAB CHARGE	TOTAL CHARGES
(mm-dd-yyyy)					$	$	$
(mm-dd-yyyy)					$	$	$
(mm-dd-yyyy)					$	$	$
(mm-dd-yyyy)					$	$	$
(mm-dd-yyyy)					$	$	$
(mm-dd-yyyy)					$	$	$
(mm-dd-yyyy)					$	$	$
(mm-dd-yyyy)					$	$	$
(mm-dd-yyyy)					$	$	$
					GRAND TOTAL		$ 0

PART 5 — STUDENT INFORMATION

Policy number: 80993 | Student ID number (9 digits) | Group name: SFU-GSS Dental Plan | Daytime phone number (10 digits)

Student's first name | Student's last name | Student's birthdate (mm-dd-yyyy)

PART 6 — PATIENT INFORMATION

Relationship to student: ☐ Self ☐ Spouse ☐ Child | Patient's birthdate (mm-dd-yyyy)

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)
X

Date (mm-dd-yyyy)

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 ☐ Full-time ☐ Part-time ☐ Retiree	Coverage type ☐ Single ☐ Family	Name of insuring company
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:
   - Student's full name
   - Patient's full name, relationship to student and birthdate
   - Student's policy and ID numbers
   - Student's mailing address if claim is pay-student
   - Dentist's signature or authorization (or attached receipts)
   - Dentist's name and unique number
   - Indicate if Pacific Blue Cross should reimburse the student 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®

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

DROP IT OFF
4250 Canada Way
Burnaby, BC V5G 4W6

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