Royal Canadian Mounted Police | Gendarmerie royale du Canada

Canadian Dental Association / L'Association dentaire canadienne

Canadian Life and Health Insurance Association Inc.

MEMBERS ONLY DENTAL PROGRAM PLAN NUMBER 3241-000

PART 1 DENTIST

UNIQUE NO. | SPEC | PATIENT'S OFFICE ACCOUNT NO.

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.

SIGNATURE OF SUBSCRIBER

PATIENT

FIRST NAME LAST NAME

ADDRESS APT.

CITY PROV.

POSTAL CODE

DENTIST

PHONE NO.

FOR DENTIST'S USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION.

DUPLICATE FORM ☐

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 DENTIST 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.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION

DATE OF SERVICE DAY	MO.	YR.	PROCEDURE CODE	INTL TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE.

TOTAL FEE SUBMITTED

INSTRUCTIONS

1. DENTIST COMPLETE PART 1
2. MEMBER COMPLETE PART 2

FORWARD ALL CLAIMS TO:
MEDAVIE BLUE CROSS
644 MAIN STREET
PO BOX 220
MONCTON NB E1C 8L3

IF YOU HAVE ANY QUESTIONS, PLEASE CALL
1-888-332-DENT (3368).
FAX: 1-506-869-9669

PART 2 - MEMBER

LAST \NAME | INITIAL(S)

EMPLOYEE I. D. NUMBER | DIVISION | COLLATOR NO.

IF CLAIM IS FOR DENTURE, CROWN OR BRIDGE, IS THIS AN INITIAL PLACEMENT?
❑ YES ❑ NO

I CERTIFY THAT I AM ENTITLED TO DENTAL TREATMENT AT RCMP EXPENSE, AND THE CONDITION TREATED IS NOT SUBJECT TO A WAIVER.

SIGNATURE OF MEMBER

DATE: YEAR | MONTH | DAY

THIS FORM MUST BE COMPLETED

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL.

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SPECIAL AUTHORIZATION NUMBER

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