MANITOBA BLUE CROSS®

DENTAL CLAIM FORM

CINUP

Please Return Completed Claims To:
CINUP
491 Portage Avenue
Winnipeg, MB. R3B 2E4
Phone: 1-800-665-1234
Fax: 1-877-786-3889

DENTIST/DENTURIST

DENTIST/DENTURIST NO.: 56789
DENTIST/DENTURIST NAME: DR. DENTIST
ADDRESS: 456 STREET
CITY/PROVINCE: WINNIPEG, MB
POSTAL CODE: A0A0A0

SERVICES FOR BENEFITS HAVE BEEN
☒ PERFORMED ☐ PLANNED

PRE-AUTHORIZATION REQUIRED FOR ALL ACCOUNTS $500.00 OR MORE

EMPLOYEE

CERTIFICATE NUMBER: 101234 5
POLICY: 3 DIV 1
SURNAME: SMITH
FIRST NAME: BOBBY
ADDRESS: 123 MARKET STREET
BIRTH DATE (DAY MON. YEAR): 30 11 72
CITY, PROVINCE: WINNIPEG MB
POSTAL CODE: A0A0A0

HAS YOUR ADDRESS CHANGED IN THE PAST 12 MONTHS? ☐ YES ☐ NO

PATIENT

IS TREATMENT REQUIRED AS A RESULT OF ACCIDENT?
☐ YES ☒ NO IF YES, GIVE DETAILS

PATIENT

PATIENT INFORMATION MUST BE GIVEN
PATIENT'S FIRST NAME: BOBBY JR
BIRTH DATE (DAY / MON. / YEAR): 12 12 80
RELATIONSHIP TO EMPLOYEE: ☐ 1 SELF ☐ 2 SPOUSE ☒ 3 DEPENDENT
☐ STATUS ☐ NON-STATUS
PHONE HOME: 1234567 OFFICE:

EMPLOYEE

ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER INSURANCE OR DENTAL PLAN?
☒ YES ☐ NO IF YES, COMPLETE THE FOLLOWING
PERSON INSURED UNDER OTHER PLAN: MARY SMITH
BIRTH DATE: 30 / 11 / 72 (DAY / MONTH / YEAR)
EMPLOYER: ABC COMPANY
EMPLOYER'S INSURANCE COMPANY: DEF COMPANY
POLICY OR CONTRACT NUMBER: 1234

IF PATIENT IS A DEPENDENT CHILD OVER THE AGE OF 18, PLEASE COMPLETE THE FOLLOWING:
1. AGE OF THE CHILD _____
2. IS HE/SHE MARRIED ☐ YES ☐ NO
3. IS HE/SHE EMPLOYED FULL TIME ☐ YES ☐ NO
4. IS HE/SHE IN FULL TIME ATTENDANCE AT SCHOOL, COLLEGE, OR UNIVERSITY ☐ YES ☐ NO
5. IS HE/SHE PHYSICALLY OR MENTALLY INCAPACITATED AND DEPENDENT ON YOU FOR SUPPORT ☐ YES ☐ NO

PATIENT/EMPLOYEE

I CERTIFY THAT I AM AWARE OF AND HAVE READ THE AUTHORIZATION AND CONSENT ON THE REVERSE SIDE OF THIS CLAIM FORM. I UNDERSTAND THAT THE CHARGES LISTED MAY NOT BE COVERED BY OR MAY EXCEED MY POLICY BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST/DENTURIST FOR THE ENTIRE COST OF THE TREATMENT.
IS PAYMENT TO BE MADE TO THE DENTIST/DENTURIST? ☐ YES ☒ NO

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN): D Smith

PLEASE ATTACH THE NON-INSURED HEALTH BENEFITS STATEMENT OF PAYMENT OR DENIAL AND/OR ANY APPLICABLE STATEMENTS FROM OTHER INSURERS.

3 - DENTIST/DENTURIST — **Examination and Treatment Record**

SERVICES PERFOR. DAY	MON.	YR.	TOOTH CODE INT.NO.	PROCEDURE NUMBER	SPECIFIC SURFACES FILLED	SERVICE MATERIAL	QTY. OR UNITS	AMOUNT BILLED	BLUE CROSS PAYS	REJECT REASON
12	07	08		53021		CUST PARTIAL TOOTHBORNE (LAB FEES ONLY)		229.46		
								$ 229.46	$	

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE ARE CORRECT AND REPRESENT THOSE RENDERED TO THE PATIENT NAMED.

DENTIST'S/DENTURIST'S SIGNATURE: DR DENTIST DATE: 7/12/08

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