



Duplicate Form

Predetermination

1. DENTAL SERVICE PROVIDER

PATIENT	NAME (LAST, FIRST)			PROVIDER	UNIQUE NO.	SPECIALTY	PATIENT'S OFFICE ACC'T NO.	I hereby assign my benefits payable from this claim to the named dentist and authorize payment directly to him/her. _____ SIGNATURE OF MEMBER
	ADDRESS				NAME/ADDRESS			
	CITY	PROVINCE	POSTAL CODE		TELEPHONE NUMBER			

FOR DENTIST USE ONLY – For additional information, diagnosis, procedure or special consideration.

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 the Administrator.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION:

Was this emergency treatment? No Yes – If yes, please provide additional details

If charges will be \$300.00 or more, your claim should be submitted for predetermination of benefits.

DATE OF SERVICE (MONTH/DAY/YEAR)	PROCEDURE CODE	TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

Failure to provide procedure codes may result in delay of processing this claim.

TOTAL FEE SUBMITTED

2. PATIENT INFORMATION

Complete this section before taking the form to your dentist's office

1. Patient: Relationship to Member: _____ Date of Birth: _____ If Child, please indicate Full-Time Student Disabled If student, indicate school attending: _____ Date enrolled: _____ Date Completed: _____ 2. Are any dental benefits or services provided under any other group insurance, government agency, W.C.B. or dental plan? No Yes – If yes, attach co-insurance statement. If this claim is for a child, please indicate spouse's date of birth: _____	3. Is the treatment result of an accident, occupational illness or injury, or otherwise related to employment? No Yes – If yes give details separately. 4. If denture, crown or bridge, is this the initial placement? Yes No If initial placement, advise date teeth were extracted _____ List all other missing teeth in arch _____ If replacement, give date of prior placement and reason for replacement: _____ 5. Is any treatment required for orthodontic purposes? Yes No Is any treatment from TMJ purposes? Yes No
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3. MEMBER INFORMATION

GROUP NUMBER 6128	PLAN NAME BRICKLAYERS & ALLIED CRAFTWORKERS INSURANCE BENEFIT TRUST FUND OF ALBERTA AND SASKATCHEWAN	CARRIER FAS	CARRIER ID 610614
NAME (LAST, FIRST)		Your CERT. No. Or I.D. No.	DATE OF BIRTH
ADDRESS		PROVINCE	PHONE NUMBER

I hereby authorize any healthcare provider, my plan administrator, my employer, insurance companies, other organizations, or benefit service providers working with Manulife Financial to exchange information when necessary for the purpose of settlement of this claim and to administer the group plan. I authorize release of the information contained in this claim form to the Insurer/Plan Administrator, its authorized representative or consultant for the purpose of settlement of this claim. I understand the information collected is kept in strict confidence and used solely for the purpose of assessing the claim and to administer the group benefit plan. I certify that the information given is true, correct and complete to the best of my knowledge and that each of the above expenses are for medical treatment that I and/or my dependents received. 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 the supplier for the entire amount.

Do you want any unpaid portion of your claim processed through your Health Spending Account? Yes No

SIGNATURE OF MEMBER

DATE



Please return to:

Ellement Consulting Group
 1050-11150 Jasper Ave NW, Edmonton AB, T5K 0C7
 Toll free: 1-800-770-2998

Phone (780) 452-5161

Fax (780) 452-5388