

## BRICKLAYERS & ALLIED CRAFTWORKERS INSURANCE BENEFIT TRUST FUND OF ALBERTA AND SASKATCHEWAN

									Duplica	ate Form		Predetermination
1.	DENTAL SEI	RVI <u>CE PR</u>										
P A	1	NAME (LAST, FIRST)				UNIQUE NO.		ECIALTY	PATIENT'S OFF	TICE ACC'T NO.	payabl the nar	by assign my benefits e from this claim to med dentist and
T I E N	ADDRESS CITY PROVINCE POSTAL CODE				O V I D E	NAME/ADDRESS					authorize payment directly to him/her.	
т						<b>TELEPHONE</b>	TELEPHONE NUMBER				SIGNATURE OF MEMBER	
For	DENTIST USE O	NLY — For addi	itional information	n, diagnosis, procedure	or spe	cial consideration.	I understand that the fees listed in this claim may not be covered by or may exceed my plan benefit 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 service rendered. I authorize release of the information contained in this claim form to the Administrator.					
						SIGNATURE OF PATIENT (PARENT/GUA						
Was this emergency treatment? No Yes - If yes, please provide						ditional details						
		lf char	ges will be \$	\$300.00 or more,	you	r claim should	d be sul	bmitted fo	or predetermi	nation of ben	efits.	
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.	<b>PATIENT INF</b>		אר									
		ORMATIC	JN				Com	plete this	section befo	re taking the	form to	your dentist's office
1. 1	Patient: Relationship to	Member:		Date of Birth:		3. lst	he treatme	ent result of a	n accident, occupat	ional illness or injur	y, or otherw	vise related to employment?
1. I	Patient: Relationship to f Child, please indicate	o Member: e Full-Ti	ïme Student	Date of Birth: Disabled			he treatme	ent result of a	n accident, occupat Yes	ional illness or injur – If yes give details	y, or otherw separately.	vise related to employment?
1.   	Patient: Relationship to	o Member: e Full-Ti	ïme Student	Disabled		4. If d	he treatme I enture, cro	ent result of a No own or bridge	n accident, occupat Yes , is this the initial pla	ional illness or injur – If yes give details acement?	y, or otherw	vise related to employment?
1.   	Patient: Relationship to f Child, please indicate f student, indicate sch	o Member: e Full-Ti	ïme Student			4. lfd lfir	he treatme I enture, cro hitial placer	ent result of a No own or bridge	n accident, occupat Yes , is this the initial pla date teeth were ext	ional illness or injur – If yes give details acement?	y, or otherw separately.	vise related to employment?
1.	Patient: Relationship to f Child, please indicato f student, indicate sch Date enrolled:	o Member: e Full-Ti ool attending:	ime Student	Disabled		4. If d If ir Lis	he treatme I enture, cro hitial placer t all other n	ent result of a No own or bridge ment, advise nissing teeth	n accident, occupat Yes , is this the initial pla date teeth were ext	ional illness or injur – If yes give details acement? racted	y, or otherw separately. Yes	vise related to employment?
1.       2. /	Patient: Relationship to f Child, please indicate f student, indicate sch Date enrolled: Are any dental benefitt agency, W.C.B. or der	o Member: e Full-Tri ool attending: s or services pro atal plan? No	ime Student Date C Divided under any OVY Yes –	Disabled Completed: other group insurance, If yes, attach co-insura	goverr	4. If d If ir Lis nment If re atement.	he treatme I enture, cro nitial placer t all other n eplacemen	ent result of an No own or bridge ment, advise nissing teeth at, give date o	n accident, occupat Yes , is this the initial pla date teeth were ext in arch of prior placement a	ional illness or injur, – If yes give details acement? racted nd reason for replace	y, or otherw s separately. Yes  cement	ise related to employment? No
1.       2. /	Patient: Relationship to f Child, please indicate f student, indicate sch Date enrolled: Are any dental benefits	o Member: e Full-Tri ool attending: s or services pro atal plan? No	ime Student Date C Divided under any OVY Yes –	Disabled Completed: other group insurance, If yes, attach co-insura	goverr	A. If d If ir Lis nment If rr atement. 5. Is a	he treatme I enture, cro nitial placer t all other n eplacemen	ent result of an No own or bridge ment, advise nissing teeth at, give date o	n accident, occupat Yes , is this the initial pla date teeth were ext in arch of prior placement a	ional illness or injur, – If yes give details acement? racted nd reason for replac    	y, or otherw separately. Yes	vise related to employment?
1.       2. /	Patient: Relationship to f Child, please indicate f student, indicate sch Date enrolled: Are any dental benefitt agency, W.C.B. or der	D Member: B Full-Tri cool attending: s or services pro- tal plan? Ne d, please indica	ime Student Date C vided under any o Yes – te spouse's date	Disabled Completed: other group insurance, If yes, attach co-insura	goverr	A. If d If ir Lis nment If rr atement. 5. Is a	he treatme I enture, cro nitial placer t all other n eplacemen	ent result of an No own or bridge ment, advise missing teeth nt, give date o ent required f	n accident, occupat Yes , is this the initial pla date teeth were ext in arch of prior placement a	ional illness or injur, – If yes give details acement? racted nd reason for replac    	y, or otherw separately. Yes  cement Yes	ise related to employment? No No
1.     2. / 3.	Patient: Relationship to f Child, please indicate f student, indicate sch Date enrolled: Are any dental benefits agency, W.C.B. or der f this claim is for a chil	D Member: B Full-Tri cool attending: s or services pro- tal plan? Ne d, please indica	ime Student Date C vided under any o Yes – te spouse's date	Disabled Completed: other group insurance, If yes, attach co-insura	goverr	A. If d If ir Lis nment If rr atement. 5. Is a	he treatme I enture, cro nitial placer t all other n eplacemen	ent result of an No own or bridge ment, advise missing teeth nt, give date o ent required f	n accident, occupat Yes , is this the initial pla date teeth were ext in arch of prior placement a	ional illness or injur, – If yes give details acement? racted nd reason for replac    	y, or otherw separately. Yes 	ise related to employment? No No
1.     2. / 3.	Patient: Relationship to f Child, please indicate f student, indicate sch Date enrolled: Are any dental benefits agency, W.C.B. or der f this claim is for a chil MEMBER INI	D Member:  Full-Tri ool attending: s or services pro tal plan? No d, please indica FORMATIC	ime Student Date C Divided under any o Yes – ite spouse's date ON AYERS & ALLI	Disabled Completed: other group insurance, If yes, attach co-insura of birth:	goverr nce sta	4. If d If ir Lis anment If rr atement. 5. Is a Is a	he treatme I enture, cro hitial placer t all other n eplacemen any treatme	ent result of an No own or bridge ment, advise missing teeth nt, give date o ent required f	n accident, occupat Yes , is this the initial pla date teeth were ext in arch of prior placement a for orthodontic purp purposes?	ional illness or injur, – If yes give details acement? racted nd reason for replac    	y, or otherw separately: Yes  Yes Yes CA	ise related to employment? . No No No No No No
1. 1 1. 1 2. 7 3. GRC	Patient: Relationship to f Child, please indicate f student, indicate sch Date enrolled: Are any dental benefits agency, W.C.B. or der f this claim is for a chil MEMBER INI DUP NUMBER	D Member:  Full-Tri ool attending: s or services pro tal plan? No d, please indica FORMATIC	ime Student Date C Divided under any o Yes – ite spouse's date ON AYERS & ALLI	Disabled Completed: other group insurance, If yes, attach co-insura of birth: PLAN NAME ED CRAFTWORKE	goverr nce sta	4. If d If ir Lis anment If rr atement. 5. Is a Is a	he treatme r enture, cro nitial placer t all other n eplacemen any treatme any treatme	ent result of an No ment, advise missing teeth tt, give date o ent required fi ent from TMJ	n accident, occupat Yes , is this the initial pla date teeth were ext in arch of prior placement a for orthodontic purp purposes? CARRIER	ional illness or injur, – If yes give details acement? racted nd reason for replac pses?	y, or otherw separately: Yes  Yes Yes CA 6	No No No No NRRIER ID
1.   1.   2. / 3. GRO NAM	Patient: Relationship to f Child, please indicate f student, indicate sch Date enrolled: Are any dental benefits agency, W.C.B. or der f this claim is for a chil MEMBER INI DUP NUMBER 6128	D Member:  Full-Tri ool attending: s or services pro tal plan? No d, please indica FORMATIC	ime Student Date C Divided under any o Yes – ite spouse's date ON AYERS & ALLI	Disabled Completed: other group insurance, If yes, attach co-insura of birth: PLAN NAME ED CRAFTWORKE	goverr nce sta	4. If d If ir Lis anment If rr atement. 5. Is a Is a	he treatme t enture, cro nitial placer t all other n aplacemen any treatme any treatme EFIT	ent result of an No wwn or bridge ment, advise nissing teeth it, give date o ent required f ent from TMJ	n accident, occupat Yes , is this the initial pla date teeth were ext in arch of prior placement a for orthodontic purp purposes? CARRIER FAS	ional illness or injur, – If yes give details acement? racted nd reason for replac pses?	y, or otherw separately Yes Cement Yes CA 6 DATI	No No No No No No No No No No No
1. I I I I I I I I I I I I I I I I I I I	Patient: Relationship to f Child, please indicate f student, indicate sch Date enrolled: Are any dental benefits agency, W.C.B. or der f this claim is for a chil MEMBER INI DUP NUMBER 6128 ME (LAST, FIRST) DRESS	b Member:	ime Student Date C Divided under any o Yes – ite spouse's date ON AYERS & ALLI FRUST FUND C , my plan adminis ent of this claim a e of settlement of in this claim may in	Disabled Completed:	govern nce sta RS IN SASK		he treatme	ent result of an No wwn or bridge ment, advise nissing teeth it, give date o ent required f ent from TMJ Your CE Po Po pons, or benefin formation co strict confiden	n accident, occupat Yes , is this the initial pla date teeth were ext in arch of prior placement a for orthodontic purp l purposes? CARRIER FAS RT. NO. OR I.D OSTAL CODE	ional illness or injur,  If yes give details acement?  racted  oraceon for replace  oses?  No.  working with Manuli form to the Insure for the purpose of a are for medical tree	y, or otherw separately: Yes Cement. Yes Yes CA 6 DATI PHON ife Financial r/Plan Admi assessing th atment that	Ities related to employment? No No No No RRIER ID I
1. I I I I I I I I I I I I I I I I I I I	Patient: Relationship to f Child, please indicate f student, indicate sch Date enrolled: Are any dental benefits agency, W.C.B. or der f this claim is for a chil MEMBER INI DUP NUMBER 6128 ME (LAST, FIRST) DRESS	b Member: a Full-Tri cool attending: s or services pro- tal plan? Ne d, please indica FORMATIC BRICKLA BRICKLA T thcare provider, pose of settlerm thorae provider, pose of settlerm thorae provider, pose of settlerm pose of settlerm thorae provider, pose of settlerm pose of settlerm pose of settlerm pose of settlerm pose of settlerm pose of settlerm pose of settlerm	ime Student Date C Divided under any o Yes – ite spouse's date ON AYERS & ALLI FRUST FUND C , my plan adminis ent of this claim a e of settlement of in this claim may in	Disabled Completed: other group insurance, If yes, attach co-insura of birth: PLAN NAME ED CRAFTWORKEI DF ALBERTA AND S Interference of the group of the coveree of the group of the group of the group of the coveree of the group of the coveree of the or the or the coveree of the or the o	govern nce sta RS IN SASK		he treatme	ent result of ai No wwn or bridge ment, advise nissing teeth it, give date o ent required f ent from TMJ Your CE Pors, or benefin formation co trict confiden hat each of th stand that I ai	n accident, occupat Yes , is this the initial pla date teeth were ext in arch of prior placement a for orthodontic purp l purposes? CARRIER FAS RT. NO. OR I.D OSTAL CODE	ional illness or injur,  If yes give details acement?  racted  oraceon for replace  oses?  No.  working with Manuli form to the Insure for the purpose of a are for medical tree	y, or otherw separately: Yes Cement. Yes Yes CA 6 DATI PHON ife Financial r/Plan Admi assessing th atment that	Ities related to employment? No No No No RRIER ID I
1. I I I I I I I I I I I I I I I I I I I	Patient: Relationship to f Child, please indicate f child, please indicate f student, indicate sch Date enrolled: Are any dental benefit agency, W.C.B. or der f this claim is for a chil <b>MEMBER INI</b> <b>DUP NUMBER</b> <b>6128</b> <b>ME (LAST, FIRST)</b> <b>DRESS</b> PRESS	b Member: a Full-Tri cool attending: s or services pro- tal plan? Ne d, please indica FORMATIC BRICKLA BRICKLA T thcare provider, pose of settlerm thorae provider, pose of settlerm thorae provider, pose of settlerm pose of settlerm thorae provider, pose of settlerm pose of settlerm pose of settlerm pose of settlerm pose of settlerm pose of settlerm pose of settlerm	ime Student Date C Divided under any o Yes – ite spouse's date ON AYERS & ALLI FRUST FUND C , my plan adminis ent of this claim a e of settlement of in this claim may in	Disabled Completed: other group insurance, If yes, attach co-insura of birth: PLAN NAME ED CRAFTWORKEI DF ALBERTA AND S Interference of the group of the coveree of the group of the group of the group of the coveree of the group of the coveree of the or the or the coveree of the or the o	govern nce sta RS IN SASK suranc oup plata t the in t the to t the in t ay exc ding A		he treatme	ent result of an No wwn or bridge ment, advise i nissing teeth it, give date o ent required f ent from TMJ Your CE Pons, or benefin formation co trict confiden that each of tt stand that I an No	n accident, occupat Yes , is this the initial pla date teeth were ext in arch of prior placement a for orthodontic purp purposes? CARRIER FAS RT. NO. Or I.D OSTAL CODE	ional illness or injur,  If yes give details acement?  racted  oraceon for replace  oses?  No.  working with Manuli form to the Insure for the purpose of a are for medical tree	y, or otherw separately: Yes Cement. Yes Yes CA 6 DATI PHON ife Financial r/Plan Admi assessing th atment that	Ities related to employment? No No No No RRIER ID I

10154 – 108 St NW, Edmonton AB, T5J 1L3 Toll free: 1-800-770-2998