Health Canada / Santé Canada

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☐ FOR **POST DETERMINATION** ☐ FOR **PREDETERMINATION** ☐ FOR **CLAIM**

FOR BASIC OR EMERGENCY SERVICES ONLY

The Asterisk (*) Identifies Mandatory Fields

PART ONE – TO BE COMPLETED BY THE PROVIDER

CLIENT INFORMATION

*SURNAME

*GIVEN NAME

*ADDRESS

APT.

*CITY

*PROVINCE *POSTAL CODE

PROVIDER INFORMATION

*PROVIDER NO. OFFICE ID.

*CLINIC ADDRESS

PHONE NO.

PAYMENT WILL BE MADE TO THE PROVIDER UNLESS INDICATED BELOW.

☐ **PAY CLIENT/GUARDIAN**

PLEASE PROVIDE PAYEE NAME AND ADDRESS IF DIFFERENT FROM CLIENT. PAYEE MUST BE 16 YEARS OF AGE.

SURNAME GIVEN NAME

ADDRESS APT.

CITY

PROVINCE POSTAL CODE

***OFFICE VERIFICATION/SIGNATURE OF PROVIDER:**

PROVIDER USE ONLY - ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES OR SPECIAL CONSIDERATION:

I AUTHORIZE THE RELEASE OF ANY RECORDS THAT ARE RELEVANT TO THE PROCESSING AND PAYMENT OF THIS CLAIM, HELD BY THE SERVICE PROVIDER TO HEALTH CANADA, ITS AGENTS OR CONTRACTORS, OR ANY APPROPRIATE HEALTH PROFESSIONAL LICENSING OR REGULATORY BODY FOR THE PURPOSES OF ADMINISTRATIVE AUDIT.

SIGNATURE OF CLIENT (PARENT/GUARDIAN)

NO	DATE OF SERVICE	PROCEDURE CODE	INT. TOOTH CODE	TOOTH SURFACES	PROFESSIONAL FEE	LABORATORY FEE	TOTAL FEE	PREDETERMINATION NUMBER	PD CENTRE APPROVED			
	(yyyy-mm-dd)	(5 digits)	(2 digits)	(5 digits)	(include decimal)	(include decimal)	(include decimal)	(10 digits)	YES	NO	N/A	AC
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
					TOTAL FEE SUBMITTED $			SERVICES WILL BE REIMBURSED ACCORDING TO THE APPLICABLE PD CENTRE TERMS AND CONDITIONS.				

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE

PART TWO CLIENT IDENTIFICATION TO BE COMPLETED BY THE PROVIDER

*CLIENT IDENTIFICATION NO.: _____ OR *BAND NO.:_____ **AND** *FAMILY NO.: _____

NOTE: BAND NO. AND FAMILY NO. DO NOT APPLY TO INUIT AND INNU CLIENTS.

*DATE OF BIRTH: _____

YYYY-MM-DD

PART THREE ADDITIONAL INFORMATION TO BE COMPLETED BY THE PROVIDER

A. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN, W.C.B., GOVERNMENT PLAN; OR IF A RESULT OF AN ACCIDENT, A MOTOR VEHICLE OR ACCIDENT INSURANCE PLAN? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE

POLICY NUMBER: _____ NAME OF INSURING PLAN OR AGENCY: _____

B. ARE THERE ANY MISSING TEETH? ☐ YES ☐ NO IF **YES**, MARK EACH TOOTH NUMBER BELOW WITH A "**X**":

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	55	54	53	52	51	61	62	63	64	65
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	85	84	83	82	81	71	72	73	74	75

PART FOUR - PREDETERMINATION TO BE COMPLETED BY FNIH

THE ABOVE SUBMISSION IS: ☐ COVERED ☐ NOT COVERED

FNIH AUTHORIZING OFFICER:

☐ CR NUMBER _____

DATE: _____
DAY/ MONTH/ YEAR

_____
SIGNATURE

ADDRESS FOR CLAIM SUBMISSION

PROVIDER PAYMENT OF CLAIMS

PLEASE SEND TO:

EXPRESS SCRIPTS CANADA
NIHB DENTAL CLAIMS
3080 YONGE STREET, SUITE 3002
TORONTO, ONTARIO M4N 3N1

FAX:

1-888-249-6098

CLIENT REIMBURSEMENT OF CLAIMS FOR ALL REGIONS EXCEPT BRITISH COLUMBIA:

PLEASE SEND TO:

THE DENTAL PREDETERMINATION CENTRE – DENTAL SERVICES/ DENTAL PREDETERMINATION CENTRE – ORTHODONTIC SERVICES - SEE BELOW FOR CONTACT INFORMATION.

ADDRESS FOR SUBMISSION REQUESTS FOR TREATMENT REQUIRING PREDETERMINATION

APPLICATIONS FOR TREATMENT REQUIRING PREDETERMINATION, PLEASE SUBMIT TO THE DENTAL PREDETERMINATION CENTRE – DENTAL SERVICES/ DENTAL PREDETERMINATION CENTRE – ORTHODONTIC SERVICES FOR ALL REGIONS, EXCEPT BRITISH COLUMBIA:

DENTAL PREDETERMINATION CENTRE
DENTAL SERVICES
NON-INSURED HEALTH BENEFITS
FIRST NATIONS AND INUIT HEALTH BRANCH
HEALTH CANADA
ADDRESS LOCATOR 1902D
2ND FLOOR, JEANNE MANCE BUILDING
200 EGLANTINE DRIVEWAY
OTTAWA, ONTARIO K1A 0K9
TOLL FREE: 1-855-618-6291
FAX: 1-855-618-6290

DENTAL PREDETERMINATION CENTRE
ORTHODONTIC SERVICES
NON-INSURED HEALTH BENEFITS
FIRST NATIONS AND INUIT HEALTH BRANCH
HEALTH CANADA
ADDRESS LOCATOR 1902C
2ND FLOOR, JEANNE MANCE BUILDING
200 EGLANTINE DRIVEWAY
OTTAWA, ONTARIO K1A 0K9
TOLL FREE: 1-866-227-0943
FAX: 1-866-227-0957

APPLICATIONS FOR DENTAL TREATMENT REQUIRING PREDETERMINATION AND CLIENT REIMBURSEMENT CLAIMS FOR BRITISH COLUMBIA, PLEASE SUBMIT TO:
(WITH THE EXCEPTION OF ORTHODONTIC SERVICES FOR BRITISH COLUMBIA)

BRITISH COLUMBIA
HEALTH BENEFITS
757 WEST HASTINGS STREET
SUITE 540
VANCOUVER, BC V6C 3E6
TOLL FREE: 1-888-321-5003
FAX: 1-604-666-5815

APPLICATIONS FOR TREATMENT REQUIRING PREDETERMINATION AND CLIENT REIMBURSEMENT OF CLAIMS FOR ORTHODONTIC SERVICES FOR BRITISH COLUMBIA, PLEASE SUBMIT TO:

ORTHODONTIC SERVICES
NON-INSURED HEALTH BENEFITS
FIRST NATIONS AND INUIT HEALTH BRANCH
HEALTH CANADA
ADDRESS LOCATOR 1902C
2ND FLOOR, JEANNE MANCE BUILDING
200 EGLANTINE DRIVEWAY
OTTAWA, ONTARIO K1A 0K9
TOLL FREE: 1-866-227-0943
FAX: 1-866-227-0957

PLEASE MAKE A COPY OF THE COMPLETED FORM AND RETAIN FOR YOUR FILES