



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 PARENT/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 INDIGENOUS SERVICES CANADA, ITS AGENTS OR CONTRACTORS, OR ANY APPROPRIATE HEALTH PROFESSIONAL LICENSING OR REGULATORY BODY FOR THE PURPOSES OF ADMINISTRATIVE REVIEW.

SIGNATURE OF CLIENT (PARENT/GUARDIAN)

NO	DATE OF SERVICE (yyyy-mm-dd)	PROCEDURE CODE (5 digits)	INT. TOOTH CODE (2 digits)	TOOTH SURFACES (5 digits)	PROFESSIONAL FEE (include decimal)	LABORATORY FEE (include decimal)	TOTAL FEE (include decimal)	PREDETERMINATION NUMBER (10 digits)	PD CENTRE APPROVED			
									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 FNHI

THE ABOVE SUBMISSION IS: COVERED NOT COVERED

FNHI AUTHORIZING OFFICER:

CR NUMBER _____

DATE: _____
DAY/ MONTH/ YEAR

SIGNATURE

ADDRESS FOR CLAIM SUBMISSION

PROVIDER PAYMENT OF CLAIMS FOR ALL REGIONS EXCEPT FOR
BRITISH COLUMBIA FIRST NATIONS RESIDENTS:

PLEASE SEND TO:

FAX:

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

1-888-249-6098

CLIENT REIMBURSEMENT OF CLAIMS FOR ALL REGIONS EXCEPT FOR
BRITISH COLUMBIA FIRST NATIONS RESIDENTS:

PLEASE SEND TO:

FAX:

EXPRESS SCRIPTS CANADA
DENTAL BENEFIT
3080 YONGE STREET, SUITE 3002,
TORONTO, ON M4N 3N1

1-888-249-6098

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 FOR BRITISH COLUMBIA FIRST NATIONS RESIDENTS:

DENTAL PREDETERMINATION CENTRE
DENTAL SERVICES
NON-INSURED HEALTH BENEFITS
FIRST NATIONS AND INUIT HEALTH BRANCH
INDIGENOUS SERVICES 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
INDIGENOUS SERVICES 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 AND ORTHODONTIC TREATMENT REQUIRING PREDETERMINATION AND CLIENT
REIMBURSEMENT CLAIMS FOR BRITISH COLUMBIA FIRST NATIONS RESIDENTS, PLEASE SUBMIT TO:

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
FIRST NATIONS RESIDENTS OF BC FNHA SUPPORT LINE: 1-855-550-5454

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