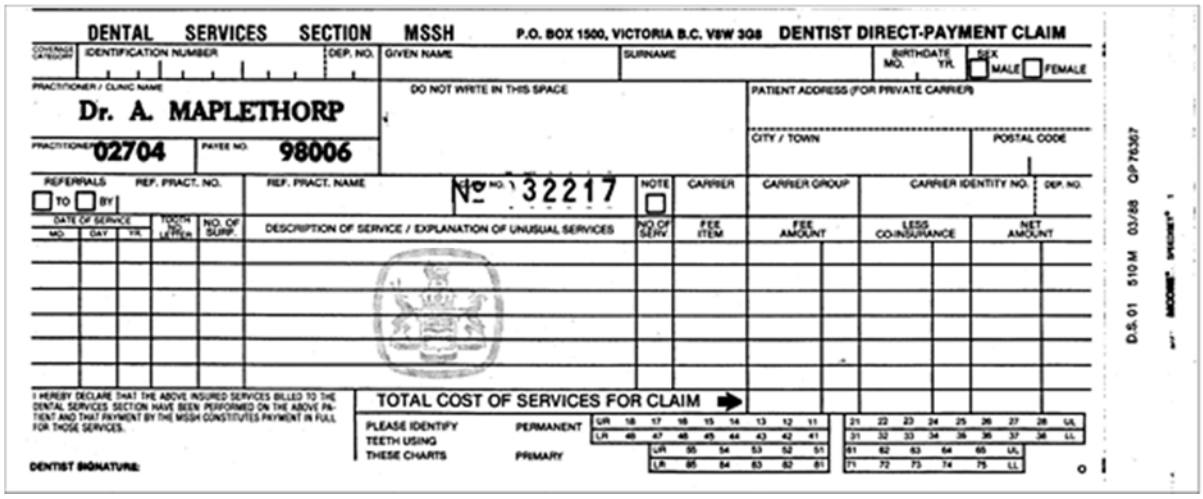
**Sample of a Ministry Claim Card**


DENTAL SERVICES SECTION MSSH P.O. BOX 1500, VICTORIA B.C. V8W 3G8 DENTIST DIRECT-PAYMENT CLAIM

IDENTIFICATION NUMBER | DEP. NO. | GIVEN NAME | SURNAME | BIRTHDATE MO. YR. | SEX MALE FEMALE

PRACTITIONER / CLINIC NAME: Dr. A. MAPLETHORP

DO NOT WRITE IN THIS SPACE

PATIENT ADDRESS (FOR PRIVATE CARRIER)

PRACTITIONER NO. 02704 PAYEE NO. 98006

CITY / TOWN | POSTAL CODE

REFERRALS TO BY | REF. PRACT. NO. | REF. PRACT. NAME | No. 32217 | NOTE | CARRIER | CARRIER GROUP | CARRIER IDENTITY NO. | DEP. NO.

| DATE OF SERVICE MO. DAY YR. | TOOTH NO. LETTER | NO. OF SURF. | DESCRIPTION OF SERVICE / EXPLANATION OF UNUSUAL SERVICES | NO. OF SERV. | FEE ITEM | FEE AMOUNT | LESS CO-INSURANCE | NET AMOUNT |
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I HEREBY DECLARE THAT THE ABOVE INSURED SERVICES BILLED TO THE DENTAL SERVICES SECTION HAVE BEEN PERFORMED ON THE ABOVE PATIENT AND THAT PAYMENT BY THE MSSH CONSTITUTES PAYMENT IN FULL FOR THOSE SERVICES.

DENTIST SIGNATURE:

TOTAL COST OF SERVICES FOR CLAIM

PLEASE IDENTIFY TEETH USING THESE CHARTS

PERMANENT: UR 18 17 16 15 14 13 12 11 | LR 48 47 46 45 44 43 42 41 | 21 22 23 24 25 26 27 28 UL | 31 32 33 34 35 36 37 38 LL

PRIMARY: UR 55 54 53 52 51 | LR 85 84 83 82 81 | 61 62 63 64 65 UL | 71 72 73 74 75 LL

D.S. 01 510M 03/88 OP 76307

Instructions:

1. Disregard this section.
2. This is the patient's new Personal health Number. This is a 10 digit number; therefore you have to enter the final number in the dependent box
3. This was the patient's Dependent number, now used for the 10th number of the PHN. Also fill in the patient's name and birthdate.
4. These sections are pre-printed on your claim card. Do not alter these sections.
5. Disregard.
6. Disregard practitioner number but complete for referring practitioner.
7. This is pre-printed. Again, do not alter.
8. This section is used only where you wish to provide information vital to the claim. Do not use to indicate re-billing.
9. Disregard.
10. This must be entered in month/day/year order.
11. Disregard.
12. This should indicate one of the following:
    - full orthodontic records (fee item 01901)
    - recall (fee item 01901)
    - initial payment (fee item 93331)
    - quarterly payment (fee item 93333)
    - miscellaneous payment (fee item 89706, to be used only where directed).
13. Fee items for the initial and quarterly payments are as outlined on the letter you received approving treatment.
14. This is used where the family contributes to the cost.
15. This section must be signed by the practitioner.
16. Disregard.

Please send only the original to Pacific Blue Cross. Copies may be retained for your records or destroyed.

Where payment of a claim is adjusted or refused, your remittance statement will indicate one of the following codes:

Key to Explanatory Codes

AB All claim details refused due to missing Practitioner's signature (or stamp) on claim.
AC Payment refused due to incomplete or incorrect billing information.
AD Patient's age outside allowable limits for billing fee item.
AE Payment refused as date of service incorrectly coded.
AF Payment refused as claim submitted later than allowed maximum time period.
AH Billed payee not in effect for date of service.
AK Payment refused as Practitioner not certified to perform service indicated.
BB Coverage not in effect for date of service shown.
BD Claim refused- identification information missing or invalid.
BG Coverage no longer available under identification number shown.
BI Patient not eligible under the identification shown.
CA Billed fee item not an allowable benefit.
CB Adjustment due to prior payment made in error, or as requested.
CD Payment refused or reduced as no referral indicated on billing card and/or patient history.
CF Payment refused (or reduced) as the allowed maximum payment amount for the service has been reached.
CG Fee item number (and/or) amount adjusted in accordance with previously paid relevant services.
CH Lab fee/specialist percentage included in amount.
CJ Adjusted to appropriate fee item, units and/or amount in accordance with information provided.
CL Patient has coverage under identification number, dependent number and/or birth date shown, please adjust your records.
CN Payment refused as specific service has already been performed by another Practitioner
CO Payment refused (or reduced) due to the previous payment of one or more relevant fee services.
CP Payment refused as required relevant fee services not billed.
CQ Payment refused as service is not a benefit for the tooth/area billed.
CR Payment refused as requested information has not been received.
CS Refer to telephone call and/or letter of explanation.
CT Payment refused (or reduced) as the allowed maximum service units have been reached.
CW Payment refused as the service has been performed within the specified time period of another relevant fee service.
CX Service has been referred to Special Care Section for consideration.
CZ Payment refused as the allowed maximum payments for relevant fee services have been reached.
DA Payment refused as other required relevant fee service(s) not billed prior to this service.
DB Only partial payment of this service has been made due to the deduction of a previously paid service which is considered to be included in this treatment.
DD Request for dental consultant approval not accepted on billing cards.
DE Payment amount reduced to the maximum allowable for the fee item.

DF Payment refused as a duplicate billing has been made.
DO Item not included in pre-authorized treatment plan.
EA This service is limited to once per tooth per lifetime and has been paid for previously.
EC Payment refused (or reduced) as annual maximum benefit for the patient has been reached.
EX Payment refused/reduced as annual maximum limit for x-rays has been reached.
FC Fee increased to applicable fee schedule amount.
FE Payment refused as no tooth number indicated.
FG Payment refused as arch is not indicated.
FH Payment refused as sextant is not indicated.
FJ Payment refused as quadrant is not indicated.
RA Retroactive adjustment to paid fee item.

Payment Policy

Where a claim is correctly completed and the service billed has been authorized, payment can be expected within 60 days of receipt of the claim. Re-billing within the 60 day period will only cause delay in processing the original billing. Other payment policies include:

1. Where treatment has been approved and initiated, a billing for an initial down-payment of 25% will be accepted. The remainder of the fee will be divided into quarterly instalments and may be billed with a date of service of the first of the month *following* the quarter. Please note that the ministry's former policy of discounting fees to 90% has been discontinued and your treatment plan will be evaluated on the basis of the 100% amount.
2. All billings must be submitted to Pacific Blue Cross ***within twelve months*** of the month following the quarter. If you fail to bill accordingly, the total approved amount will be reduced by the amount forfeited.
3. Once a treatment amount has been approved, no supplementary amount can be considered without the prior approval of the Orthodontic Administrator. Both the practitioner and the parent are advised of the approval terms and conditions
4. This approval is valid only while enhanced Ministry-sponsored medical coverage is in effect through the Ministry. **Should Ministry medical/dental coverage be cancelled for any reason, the Ministry will only pay the quarterly payment directly following the end of coverage. The family or participant must then assume the responsibility for payment of the outstanding balance or the option of cancelling treatment.**
5. Where surgery is anticipated, please advise the ministry at the time of the original application for orthodontic benefits. Requests for oral surgery technical fees will be reviewed by the ministry and pre authorization will be given in accordance with the Schedule E as negotiated by the Medical Commission and the BC Dental Association.
6. In those cases where it is necessary for a patient to be placed on a recall prior to commencement of treatment, the recall routine must be approved by the Orthodontic Administrator and, if approved, only the amount outlined in the fee schedule may be charged (i.e. fee item 01901 with a maximum of two recalls per year as necessary) .