Sample of the First Canadian Health NIHB-DENT-29 Form

Health Canada / Santé Canada

PROTECTED WHEN COMPLETED

☐ †FOR **POST APPROVAL** †For basic or emergency services only ☐ FOR **PREDETERMINATION** ☐ FOR **CLAIM**

PART 1 - PROVIDER (PROVIDER TO COMPLETE)

CLIENT: SURNAME / GIVEN NAMES / ADDRESS / APT. / CITY / PROV. / POSTAL CODE

PROVIDER NO.

PROVIDER: 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

FOR PROVIDER USE ONLY - FOR 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)

OFFICE VERIFICATION/SIGNATURE OF PROVIDER

	*DATE OF SERVICE DDMMCCYY	PROCEDURE CODE	INT. TOOTH CODE	TOOTH SURFACES	PROFESSIONAL FEE	LABORATORY FEE	TOTAL FEE	PREDETERMINATION/PREVERIFICATION NO.	FNIHB APPROVED YES	NO	N/A	AC
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

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

TOTAL FEE SUBMITTED $

SERVICES WILL BE REIMBURSED ACCORDING TO THE APPLICABLE FNIHB TERMS AND CONDITIONS.

PART 2 - CLIENT INFORMATION (PROVIDER TO COMPLETE)

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

DATE OF BIRTH ___/___/___ (DAY MONTH YEAR)

* Two fields above do not apply to Inuit and Innu clients.

PART 3 - ADDITIONAL INFORMATION (PROVIDER TO COMPLETE)

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, CIRCLE TOOTH NUMBER(S)

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

55	54	53	52	51	61	62	63	64	65
85	84	83	82	81	71	72	73	74	75

PART 4 - PREDETERMINATION (TO BE COMPLETED BY FNIHB)

THE ABOVE SUBMISSION IS ☐ APPROVED ☐ NOT APPROVED

FNIHB AUTHORIZING OFFICER:

☐ CR

NUMBER _____

DATE ___/___/___ (DAY MONTH YEAR)

SIGNATURE

NO.

A 07619299

PLEASE QUOTE THIS NUMBER ON YOUR CLAIM IF FNIHB PREDETERMINATION/ PREVERIFICATION HAS BEEN PROVIDED.

NIHB DENT29E (Printed 03/03)

FOR MAILING INSTRUCTIONS PLEASE SEE REVERSE VERSION DATE: 01/31/03 **CE FORMULAIRE EST AUSSI DISPONIBLE EN FRANÇAIS**