BRITISH COLUMBIA | Health InsuranceBC

MEDICAL SERVICES PLAN (MSP)
PAY DENTIST CLAIM

PD

CLAIMS MUST BE SUBMITTED WITHIN 90 DAYS

A B C D PLEASE USE CAPITAL LETTERS ONLY

PATIENT INFORMATION

PERSONAL HEALTH NUMBER (PHN) | DEPENDANT

PATIENT LEGAL FIRST NAME | SECOND NAME INITIAL | PATIENT LEGAL LAST NAME

PATIENT BIRTHDATE (MM / YYYY) | MVA RELATED? YES | IF YES, MVA CLAIM NUMBER | CORRESPONDENCE ATTACHED | SUBMISSION CODE | PLAN REFERENCE NUMBER OF ORIGINAL CLAIM

SERVICE(S)

DATE OF SERVICE MONTH	DAY	YEAR	NO. OF SERVICES	S.C.C.	FEE ITEM	AMOUNT BILLED	TIME CALLED START	TIME RENDERED FINISH	DIAGNOSTIC CODE	LOC. OF SERV.

PLEASE IDENTIFY TEETH ACCORDING TO CHARTS (X)

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

NOTES

PRACTITIONER INFORMATION

PRACTITIONER LAST NAME OR CLINIC NAME | FIRST NAME INITIAL | PRACTITIONER SIGNATURE

PAYMENT NUMBER | PRACTITIONER NUMBER | SPEC. CODE

REFERRED BY | PRACTITIONER NUMBER | REFERRED BY (PRACTITIONER LAST NAME) | FIRST NAME INITIAL

REFERRED TO | PRACTITIONER NUMBER | REFERRED TO (PRACTITIONER LAST NAME) | FIRST NAME INITIAL

Mailing Address: Health Insurance BC, Medical Services Plan, PO Box 9689 Stn Prov Govt, Victoria BC V8W 9P8
Tel: (Lower Mainland) 604 456-6950, (Rest of BC) 1 866 456-6950 Web: **www.hibc.gov.bc.ca**

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