

CLAIMS MUST BE SUBMITTED WITHIN 90 DAYS



A, B, C, D PLEASE USE CAPITAL LETTERS ONLY

PATIENT INI	FORMATION																			
PERSONAL HEALTH NUMBER (PHN) DEPEND																				
PATIENT LEGAL FIRST NAME SECOND NAME INITIAL PATIENT LEGAL LAST NAME																				
PATIENT BIRTHDATE (MM / YYYY) MVA RELATED? IF YES, MVA CLAIM NUMBER CORRESPONDENCE SUBMISSION ATTACHED CODE										PLAN	I REFERE	ENCE NU	MBER OF	ORIGINA	AL CLAII	м				
YES																				
SERVICE(S)												_								
			NO. OF SERVICES	S.C.C.	FE	E ITEM	AMOUNT		IT BILLED		TIME CALLED START			RENDEF FINISH		DIAGNOSTIC CODE			LOC. OF SERV.	
PLEASE IDENTI	FY TEETH ACCOF	RDING TO (<u>(</u>)																
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	2	3	24	25		26]27	28	UL	
	LR 48	47	46	45	44	43	42	41	31	32	3	3	34	35		36	37	38	LL	
NOTES																				
PRACTITIO	NER INFORMA	TION																		
PRACTITIONER LAST NAME OR CLINIC NAME											ONER	SIGNATL	JRE							
	IBER	PRACTITIC		BER	SPEC. COD	E														
REFERRED BY PRACTITIONER NUMBER REFERRED BY (PRACTITIONER LAST NAME)													FIRST NAME INITIAL							
REFERRED TO PRACTITIONER NUMBER REFERRED TO (PRACTITIONER LAST NAME)											AME INIT	ΓIAL								
Mailing Add	dress: Health	Insuran	ce BC. N	ledical S	Services F	Plan, PO E	30x 968	9 Stn Pr	ov Govt	, Victoria	a BC V	8W 9P8	3							

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