



## **DENTIST CLAIM FORM**

Quebec's Oral Health Care and Daily Oral Hygiene Program in Residential and Long-Term Care Centre (CHSLD)

File number				
Resident's last name				
Resident's first name				
Year M Date of birth	onth Day Sex			
Health insurance number	Year Month Expiry			
Area code Phone number	Area code Phone number (alt.)			

Dentist	Last name and	first name	Permit number	Date of services	Year	Month	Day
Diagnosis	s and additio	nal information					
Procedu	re (Code)	Tooth Number	Tooth Surface		Fee	s (\$)	
			1	otal fees			

ı	Certification	Dentist's signature
	I certify that I provided the above services.	