Santé et Services sociaux Québec

DT9466

DENTURIST 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

Date of birth — Year Month Day — Sex ☐ M ☐ F

Health insurance number — Expiry Year Month

Area code Phone number — Area code Phone number (alt.)

Denturist	Last name and first name	Permit number	Date of services	Year	Month	Day

Additional information

Procedure (Code)	Full Dentures		Partial Dentures		Fees ($)
	Upper	Lower	Upper	Lower	
	☐	☐	☐	☐	
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			Total fees		

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