Newfoundland Labrador
Health and Community Services

ADULT DENTAL PROGRAM
REQUEST FOR REIMBURSEMENT

mcp
Medical Care Plan

PATIENT INFORMATION

Surname	First Name

MCP Number	MCP Expiry Date	Daytime Telephone Number

AES ID Number (if applicable)	AES File Number (if applicable)	NLPDP Coverage (check one) ☐ Foundation Plan ☐ Access Plan ☐ 65 Plus Plan

MAILING ADDRESS

Street / P.O. Box

City / Town	Province	Postal Code

ELECTRONIC PAYMENT INFORMATION (you must attach a void cheque or deposit authorization form provided by your bank)

Bank Name

Bank Institution Number	Bank Transit Number	Account Number

DENTAL PROVIDER INFORMATION (to be completed by Dental Provider)

Surname	First Name

MCP Provider Billing Number	Office Telephone Number

DENTAL SERVICES PROVIDED

Date of Service (dd/mm/yyyy)	Description/Tooth Number	MCP Fee Code	Listed Rate	MCP Office Use Only	

FOR OFFICE USE ONLY

☐ Add New Supplier (individual)	Supplier Number

Department	Contact	Telephone Number	Date	Signature

AN ORIGINAL PAID-IN-FULL RECEIPT AND A LETTER OF ELIGIBILITY MUST BE ATTACHED TO THIS COMPLETED FORM AND MAILED TO THE MCP OFFICE AT THE ADDRESS NOTED BELOW.
IF PRIVATE INSURANCE APPLIES, PLEASE PROVIDE STATEMENT OF BENEFITS.

PRIVACY NOTICE
Personal health information collected, used, disclosed, and safeguarded is in accordance with the *Personal Health Information Act* (PHIA). If you have any questions about the collection or use of this information please contact our office. The Department of Health and Community Services privacy statement can be found at www.health.gov.nl.ca/health/PHIA.