MAIL TO:

STANDARD DENTAL CLAIM FORM

PART 1: DENTIST	UNIQUE #	SPEC	PATIENT ACCOUNT	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM /HER
PATIENT	DENTIST			SIGNATURE OF SUBSCRIBER

FOR DENTIST'S USE ONLY – FOR ADDITIONAL INFORMATION, DIAGNOIS, PROCEDURES OR SPECIAL CONSIDERATION

DUPLICATE FORM _____

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED OR MAY EXCEED MY PLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREATMENT. I ACKNOWLEDGE THAT THE TOTAL FEE OF $ ____ IS ACCURATE AND HAS BEEN CHARGED TO ME FOR SERVICES RENEDERED. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY / PLAN ADMINISTRATOR I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED TO THE COVERAGE OF SERVICES DESCRIBED IN THIS FORM TO THE NAMED DENTIST

_____

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

DATE			PROCEDURE	INTERNAL	TOOTH	LAB	TOTAL	FOR CARRIER USE			
DAY	MO	YR	CODE	TOOTH CODE	SURFACE	CHARGES	CHARGES	ALLOWED AMOUNT	INC	%	PATIENT SHARE
								CHEQUE NO.		DATE	
								DEDUCTIBLE:	PATIENT PAYS		PLAN PAYS

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE.	TOTAL FEE SUBMITTED:	CLAIM NO.	

INSTRUCTIONS FOR CLAIMS SUBMISSION

BEING A STANDARD FORM, THIS FORM CANNOT INCLUDED SPECIFIC INSTRUCTIONS ON WHERE IT SHOULD BE SENT, DEPENDING ON WHO IS THE CARRIER FOR YOUR PLAN, YOU CAN OBTAIN DETAILS FROM EITHER YOUR PLAN BOOKLET, YOUR CERTIFICATE OR FROM YOUR EMPLOYER. IF YOUR PLAN REQUIRES SUBMISSION DIRECTLY TO THE CARRIER, PLEASE SEND THIS FORM WITH ONLY PART 1,2 & 3 COMPLETED TO THE CARRIER'S APPROPRIATE CLAIMS OFFICE. IF YOUR PLAN REQUIRES SUBMISSION TO YOUR EMPLOYER, PLEASE DIRECT THIS FORM TO YOUR PERSONNEL OFFICE / PLAN ADMINISTRATOR WHO WILL COMPLETE PART 4 AND FORWARD THE FORM TO THE CARRIER.

PART 2 – EMPLOYEE / PLAN MEMBER / SUBSCRIBER

1 GROUP POLICY / PLAN NO.
EMPLOYER
NAME OF INSURING AGENCY OR PLAN

2 NAME
CERT/SIN/ID NO.
DATE OF BIRTH (D/M/YR)

PART 3 – PATIENT INFORMATION

1 PATIENT: RELATIONSHIP TO EMPLOYEE / PLAN MEMBER / SUBSCRIBER
DATE OF BIRTH (D/M/YR)
IF CHILD INDICATE: STUDENT _____ HANDICAPPED _____
IF STUDENT, INDICATE SCHOOL:
PATIENT ID NO.

2 ARE ANY BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN, W.C.B. OR GOV'T PLAN? NO _____ YES _____
POLICY NO. SPOUSE DATE OF BIRTH:
NAME OF OTHER INSURANCE AGENCY OR PLAN

		NO	YES
3	IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? IF YES, GIVE DATE AND DETAIL SEPERATELY		
4	IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? GIVE DATE OR PRIOR PLACEMENT AND REASON FOR REPLACEMENT. GIVE DATE & DETAILS SEPARATELY		
5	IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES?		

I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQURESTED IN RESPECT OF THIS CLAIM TO THE INSURE / PLAN ADMINISTRATOR AND CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE

DATE: (D/M/YR) _____

_____

SIGNATURE OF EMPLOYEE / PLAN MEMBER / SUBSCRIBER

PART - 4 POLICY HOLDER / EMPLOYER (FOR COMPLETION ONLY IF APPPLICABLE SEE ABOVE*)

	DAY	MONTH	YEAR
1 DATE OF COVERAGE COMMENCED			
2 DATE DEPENDANT COVERED			
3 DATE TERMINATED			

4 CONTRACT HOLDER

DAY	MONTH	YEAR

_____ AUTHORIZED SIGNATURE

_____ (POSITION OR TITLE)