



# DENTAL CLAIM FORM

<b>PART 1 – DENTIST</b>			UNIQUE NO. <input type="checkbox"/> SPEC. <input type="checkbox"/> PATIENT'S OFFICE ACCOUNT NO.			I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER							
P A T I E N T  PHONE NO.			D E N T I S T  PHONE NO.			SIGNATURE OF SUBSCRIBER							
FOR DENTIST'S USE ONLY – FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES OR SPECIAL CONSIDERATION			I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY 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 RENDERED. 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 AND THE PLAN MEMBER.										
			SIGNATURE OF PATIENT (PARENT/GUARDIAN)										
DUPLICATE FORM <input type="checkbox"/>			OFFICE VERIFICATION/DENTIST'S SIGNATURE										
DATE OF SERVICE			PROCEDURE CODE	INT'L TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES	FOR CARRIER USE				
DAY	MO.	YR.							ALLOWED AMOUNT	INC.	%	PATIENT'S SHARE	
THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & O.E.			TOTAL FEE SUBMITTED			CLAIM NO.			CHEQUE NO. _____ DATE _____				
									DEDUCTIBLE		PATIENT PAYS		PLAN PAYS

**PART 2 – EMPLOYEE / PLAN MEMBER / SUBSCRIBER**

1. GROUP POLICY / PLAN NO. \_\_\_\_\_ DIVISION / SECTION NO. \_\_\_\_\_

EMPLOYER \_\_\_\_\_

NAME OF INSURING AGENCY OR PLAN \_\_\_\_\_

2. YOUR NAME (PLEASE PRINT) \_\_\_\_\_

YOUR CERTIFICATE NO. \_\_\_\_\_

OR S.I.N. OR I.D. NO. \_\_\_\_\_

YOUR DATE OF BIRTH \_\_\_\_\_ DAY MONTH YEAR

3. DO YOU WANT ANY UNPAID BALANCE FROM THIS CLAIM REIMBURSED FROM YOUR HEALTH SERVICE SPENDING ACCOUNT (IF ELIGIBLE)? YES NO

**PART 3 – PATIENT INFORMATION**

1. PATIENT: RELATIONSHIP TO EMPLOYEE/ PLAN MEMBER / SUBSCRIBER \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ DAY MONTH YEAR

IF CHILD, INDICATE STUDENT  HANDICAPPED

IF STUDENT, INDICATE SCHOOL \_\_\_\_\_

PATIENT I.D. NO. \_\_\_\_\_

2. ARE ANY DENTAL 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 INSURING AGENCY OR PLAN \_\_\_\_\_

3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? IF YES, GIVE DATE AND DETAILS  NO  YES

4. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT  NO  YES

5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES?  NO  YES

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

DATE \_\_\_\_\_ DAY MONTH YEAR

SIGNATURE OF EMPLOYEE / PLAN MEMBER / SUBSCRIBER \_\_\_\_\_

**PART 4 – POLICY HOLDER / EMPLOYER (FOR COMPLETION ONLY IF APPLICABLE, SEE ABOVE\*)**

1. DATE COVERAGE COMMENCED	DAY	MONTH	YEAR	CONTRACT HOLDER	DAY	MONTH	YEAR	AUTHORIZED SIGNATURE	
2. DATE DEPENDENT COVERED									
3. DATE TERMINATED								(POSITION OR TITLE)	

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL. UNLESS ASSIGNED, BENEFITS ARE PAYABLE TO THE PLAN MEMBER.  
 \*\*\* NOTE: DO NOT STAPLE OR TAPE RECEIPTS TO THE CLAIM FORM \*\*\*