

DENTAL CLAIM FORM

All claims must be submitted to insurer at the address below within 6 months from the date on which the expenses are incurred and no later than November 30th, 2022. Claimants must provide a valid Canadian address for reimbursement. Claimant reimbursement cheques will not be issued to a non-Canadian address.

PART 1 – DENTIST				UNIQUE NO. ☐ SPEC. ☐ 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 _____ SIGNATURE OF SUBSCRIBER				
PATIENT				DENTIST								
PHONE NO.				PHONE NO.								
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)								
												OFFICE VERIFICATION/DENTIST'S SIGNATURE
DUPLICATE FORM ☐												
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.			

PART 2 – EMPLOYEE / PLAN MEMBER / SUBSCRIBER			
1. GROUP POLICY / PLAN NO. <u>100002</u> DIVISION / SECTION NO. _____		2. YOUR NAME (PLEASE PRINT) _____	
INSTITUTION <u>FANSHAW COLLEGE</u>		CERTIFICATE # (STUDENT #) _____	
NAME OF INSURING AGENCY OR PLAN <u>SMS, a division of IA Financial</u>		YOUR DATE OF BIRTH _____	
		DAY MONTH YEAR	

PART 3 – PATIENT INFORMATION			
1. PATIENT: RELATIONSHIP TO EMPLOYEE/ PLAN MEMBER / SUBSCRIBER _____		3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? IF YES, GIVE DATE AND DETAILS ☐ NO ☐ YES	
DATE OF BIRTH _____		4. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT ☐ NO ☐ YES	
DAY MONTH YEAR		5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? ☐ NO ☐ YES	
IF CHILD, INDICATE STUDENT ☐ HANDICAPPED ☐		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	
IF STUDENT, INDICATE SCHOOL _____		DATE _____	
PATIENT I.D. NO. _____		DAY MONTH YEAR	
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		SIGNATURE OF EMPLOYEE / PLAN MEMBER / SUBSCRIBER _____	
POLICY NO. _____ SPOUSE DATE OF BIRTH _____			
NAME OF OTHER INSURING AGENCY OR PLAN _____			

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)											