

DENTAL CLAIM FORM

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 <div style="text-align: right;">_____ SIGNATURE OF SUBSCRIBER</div>											
P A T I E N T				D E N T I S T 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. <div style="text-align: right;">_____ SIGNATURE OF PATIENT (PARENT/GUARDIAN)</div>															
				<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DUPLICATE FORM ☐ </div> <div style="width: 50%;"> OFFICE VERIFICATION/DENTIST'S SIGNATURE </div> </div>															
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
																CHEQUE NO.		DATE	
																DEDUCTIBLE		PATIENT PAYS	
																CLAIM NO.			
THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & O.E.						TOTAL FEE SUBMITTED													

PART 2 – EMPLOYEE / PLAN MEMBER / SUBSCRIBER			
1. GROUP POLICY / PLAN NO. 100003		DIVISION / SECTION NO. _____	
INSTITUTION Seneca Polytechnic		2. YOUR NAME (PLEASE PRINT) _____	
NAME OF INSURING AGENCY OR PLAN _____		CERTIFICATE # N (STUDENT #) _____	
		YOUR DATE OF BIRTH _____ DAY MONTH YEAR	

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. _____		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 _____	
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 _____			

PART 4 – POLICY HOLDER / EMPLOYER (FOR COMPLETION ONLY IF APPLICABLE, SEE ABOVE*)											
1. DATE COVERAGE COMMENCED 2. DATE DEPENDENT COVERED 3. DATE TERMINATED		CONTRACT HOLDER			DAY MONTH YEAR			_____ AUTHORIZED SIGNATURE _____ (PPOSITION OR TITLE)			
					DAY MONTH YEAR						
					DAY MONTH YEAR						
					DAY MONTH YEAR						

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL. UNLESS ASSIGNED. BENEFITS ARE PAYABLE TO THE PLAN MEMBER.