

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 _____ SIGNATURE OF SUBSCRIBER			
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. _____ 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. 514051		DIVISION / SECTION NO. _____	
INSTITUTION CAMBRIAN COLLEGE		2. YOUR NAME (PLEASE PRINT) _____	
NAME OF INSURING AGENCY OR PLAN _____		CERTIFICATE # _____ (STUDENT #) _____ B	
		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	
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 _____		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 _____ (POSITION OR TITLE)			
2. DATE DEPENDENT COVERED											
3. DATE TERMINATED											

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