



CAMBRIAN
STUDENT COUNCIL

CAMBRIAN COLLEGE 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
									CHEQUE NO.		DATE	
									DEDUCTIBLE		PATIENT PAYS	
											PLAN PAYS	
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

I. GROUP POLICY / PLAN NO. **514051** DIVISION / SECTION NO. _____ 2. YOUR NAME (PLEASE PRINT) _____
INSTITUTION **CAMBRIAN COLLEGE** CERTIFICATE # (STUDENT #) _____ **B**
NAME OF INSURING AGENCY OR PLAN _____ 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. _____
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 2. DATE DEPENDENT COVERED 3. DATE TERMINATED	DAY	MONTH	YEAR	CONTRACT HOLDER	DAY	MONTH	YEAR	_____ AUTHORIZED SIGNATURE _____ (POSITION OR TITLE)	

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