CANADIAN DENTAL ASSOCIATION

Canadian Life and Health Insurance Association Inc.

STANDARD DENTAL CLAIM FORM

PART 1 DENTIST

UNIQUE NO. 04152 | SPEC. | PATIENTS OFFICE ACCOUNT NO.

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT TO HIM/HER

SIGNATURE OF SUBSCRIBER

PATIENT

FIRST NAME LAST NAME

ADDRESS APT.

CITY PROV. POSTAL CODE

DENTIST

Dr. Robert W. Elliott
4122 15th Avenue
Prince George, BC V2M 1V9

PHONE NO. (250) 562-2113

FOR DENTIST USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES,OR SPECIAL CONSIDERATIONS.

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.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION

DATE OF SERVICE DAY	MO.	YR.	PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE.

TOTAL FEE SUBMITTED

FOR CARRIER USE

ALLOWED AMOUNT	INC	%	PATIENT'S SHARE

CHEQUE NO. DATE

DEDUCTIBLE	PATIENT PAYS	PLAN PAYS

CLAIM NO.

INSTRUCTIONS FOR CLAIM SUBMISSION

BEING A STANDARD FORM, THIS FORM CANNOT INCLUDE SPECIFIC INSTRUCTIONS ON WHERE IT SHOULD BE SENT, DEPENDING ON WHO IS THE CARRIER FOR YOUR PLAN. YOU CAN OBTAIN DETAILS FROM EITHER YOUR PLAN BOOKLET, YOUR CERTIFICATE OR FROM YOUR EMPLOYER.
IF YOU PLAN REQUIRES SUBMISSION DIRECTLY TO THE CARRIER, PLEASE SEND THIS FORM WITH ONLY PARTS 1, 2 AND 3 COMPLETED TO THE CARRIER'S APPROPRIATE CLAIMS OFFICE.
*IF YOUR PLAN REQUIRES SUBMISSION TO YOUR EMPLOYER, PLEASE DIRECT THIS FORM TO YOUR PERSONNEL OFFICE/PLAN ADMINISTRATOR WHO WILL COMPLETE PART 4 AND FORWARD THE FORM TO THE CARRIER.

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 CERT. NO. OR S.I.N. OR I.D. NO.

YOUR DATE OF BIRTH
DAY MONTH YEAR

PART 3 - PATIENT INFORMATION

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

DATE OF BIRTH IF CHILD INDICATE: ☐ STUDENT ☐ HANDICAPPED
DAY MONTH YEAR

IF STUDENT, INDICATE SCHOOL

PATIENT I.D. NO.

2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURACE 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 SEPERATELY. ☐ 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*)

	DAY	MONTH	YEAR
1. DATE COVERAGE COMMENCED			
2. DATE DEPENDENT COVERED			
3. DATE TERMINATED			

4. CONTRACT HOLDER

DATE					
DAY		MONTH		YEAR	

AUTHORIZED SIGNATURE

(POSITION OR TITLE)

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL