DENTAL CARE CLAIM FORM

NOTE: CLAIMS MUST BE SUBMITTED WITHIN 3 MONTHS OF BEING INCURRED TO BE ELIGIBLE FOR REIMBURSEMENT

1. Insured's Name (Surname, First Name, Middle Initial) | Date of Birth D M Y | 2. Plan Number | Certificate No. | Company/Plan

3. Insured's Address and Telephone Number

4. Patient's Address (if different)

5. Patient's Name (Surname, First Name, Middle Initial) | Date of Birth D M Y | Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

6. Is Patient Covered by Another Dental Plan ☐ Yes ☐ No

DENTIST OR SUPPLIER

PATIENT/INSURED INFORMATION

Is treatment result of occupational illness or injury? ☐ Yes ☐ No

Is treatment result of auto accident? ☐ Yes ☐ No

Are any services covered by another plan? ☐ Yes ☐ No

First Visit Date D M Y

Place of Treatment ☐ Office ☐ Hospital ☐ Other X-rays or models enclosed? ☐ Yes ☐ No

How Many?

Is the treatment for orthodontics ☐ Yes ☐ No

If crown, was tooth badly broken down? ☐ Yes ☐ No

If "Yes", enter brief description and dates

If "Yes", give date of extractions of teeth being replaced.

If "No", give reason for replacement and date of prior placement.

Examination and Treatment Plan. List in order. Use charting system shown.

<table>
<thead>
<tr>
<th>Tooth # or Letter</th>
<th>Surface</th>
<th>Description of Service (Including X-rays, Prophylaxis, materials used, Root canal (# of Canals), Etc)</th>
<th>Date Service Performed (d/m/y)</th>
<th>Fee</th>
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I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees that I have charged and intend to collect for those procedures.

"I HEREBY CERTIFY THAT THE ABOVE SERVICES AS INDICATED BY DATE HAVE BEEN COMPLETED."

__________________________________________________________
Signature of Dentist
Date

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PLAN ADMINISTRATOR'S SECTION

Effective Date of Insured's Coverage ____________________________  Effective Date of Dependent's Coverage ____________________________

__________________________________________________________
Signature of Administrator  Company Stamp  Date
GUIDELINES

Our goal is to process your claim within the **10 day turnaround** time we have indicated to you. In order for us to fulfil this goal, you can help us by ensuring that the following guidelines are followed:

**THE CLAIM FORM**

- Prepare a **separate claim form** for each family member.
- Complete **ALL** of the information requested with **EACH** claim submission.
- If you prefer that **benefits be paid to the provider of services**, be sure to complete the **authorization for assignment of benefits** section of the claim form.

**THE PROVIDER BILLING OR RECEIPT**

Each bill receipt should carry:

- The name, address, person or organization providing the service.
- The name of the patient receiving the service.
- The date of each service (**a range of services cannot be accepted**).
- The charge for each individual service.
- A description of each service.

On each bill, please delete any charges that were included on a previous claim. Personal itemizations, cash register receipts, credit card receipts and cancelled cheques are not acceptable. **PLEASE NOTE THAT ORIGINAL RECEIPTS CANNOT BE RETURNED UNLESS ACCOMPANIED BY CLEAR COPIES.**

**Accidental Injury** - Statements must contain details as to when, where and the manner in which the injury occurred as well as the name and address of the party at fault where applicable.

**Prescription only drugs** - Bills/receipts must include the prescription number, the name of the drug and the name of the physician prescribing the medication. **(Please note that the cost of each drug must be indicated and receipts must carry the name/stamp of the pharmacy)**

**Private Duty Nursing** - Bills/receipts must include the shift worked, the charge per hour, the number of hours worked, the nurse's professional status, the family relationship to the patient if any. A statement from the attending physician explaining the necessity of this service and the authorization of the service should accompany the claim.

**Prosthetic appliances and the rental or purchase of durable equipment** - A statement from the attending physician should accompany the claim. The statement should explain the medical necessity of the equipment and the physician's authorization for it.

**For patients covered by another insurance carrier** - If the patient is claiming benefits for any charges that are eligible for benefits under any other health insurance policy, the explanation of benefits worksheet furnished by the other company pertaining to these expenses must be included with the itemized bills. A **CLEAR** copy of the other carrier's explanation of benefits worksheet is acceptable in place of the original document.

Have you?
- Fully completed and signed the claim form.
- Attached all relating itemized bills/receipts.
- Kept copies of documentation for your records.
- Had your Plan administrator complete the employer's section.