

DENTAL CLAIM FORM

PART 1 - PROVIDER								Unique No.		Spec		Patient's Office Account No.						I hereby assign my benefits payable from this claim to the named provider and authorized payment directly to him/her					
P	Patient Last Name _____ Given Name _____							P R O V I D E N T Phone No _____															
A	· _____																						
T	Address _____ Apt. _____																						
I	_____																						
E	City _____ Prov. _____ Postal Code _____																	Signature of Plan Member					
N																	For provider's use only - for additional information, diagnosis, procedures, or special consideration.						
T																	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 provider 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 provider. Signature of Patient (Parent/Guardian)_____						
Duplicate Form ☐																Office Verification							
Date of Service DAY MO YR.		Procedure Code			Int'l Tooth Code	Tooth Surfaces	Provider's Fee			Laboratory Charges			Total Charges			Allowed Amount	Code						
This is an accurate statement of services performed and the total fee due and payable, E & OE.								TOTAL FEE SUBMITTED															

INSTRUCTIONS FOR CLAIM SUBMISSION:

Please carefully fill in all pertinent areas and sign the completed form. (Refer to Green Shield Identification Card for correct patient information). Incomplete or incorrect claim forms will be returned or rejected and will result in a delay in reimbursement.

PART 2 - EMPLOYEE/PLAN MEMBER		All claims must be submitted within 12 months of the date of service (unless otherwise stated in your benefit plan documentation).								
Plan Member's Name (Please Print)		Plan Member's Identification Number		Plan Member's Date of Birth						
		-00		<table border="1"> <tr> <td>Yr</td> <td>Mo</td> <td>Day</td> </tr> <tr> <td></td> <td></td> <td></td> </tr> </table>	Yr	Mo	Day			
Yr	Mo	Day								
Last Name		Given Names								

PART 3 - PATIENT INFORMATION				
Patient's Name (Please print) 	Patient's Identification Number 	Patient's Date of Birth Yr Mo Day		
Last Name 	Given Names 			
1. Patient: Relationship to Plan Member If child, indicate: Student ☐ Handicapped ☐ If student, indicate school 2. Are any dental benefits or services provided under any other group insurance or dental plan, W.S.I.B. or Government plan? No ☐ Yes ☐ If 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 separately. 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 ☐ I authorize the release of any information or records required in respect of this claim to insurer/plan administrator and certify that the information given is true, correct and complete to the best of my knowledge.				
All information recorded on this form is confidential.			Signature of Plan Member 	
By signing this claim form and/or submitting actual receipts, I agree that the information provided on this form is complete and accurate. I understand that the information provided by me to Green Shield Canada about myself and my dependents, will be used by Green Shield Canada for claims adjudication and any other services necessary in the administration of our benefits which may include the exchange of information with other parties to administer this benefit claim. I am authorized by my spouse and/or dependents to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder.			Date Day Month Year	