



**Canadian Life and Health Insurance Association Inc.**

# STANDARD DENTAL CLAIM FORM

PART 1 DENTIST			UNIQUE NO.	SPEC.	PATIENTS OFFICE ACCOUNT NO.	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT TO HIM/HER
P A T I E N T	<div> <div></div> <div>FIRST NAME</div> <div></div> <div>LAST NAME</div> </div>		D E N T I S T			
	<div> <div></div> <div>ADDRESS</div> <div></div> <div>APT.</div> </div>					
	<div> <div></div> <div>CITY</div> <div>PROV.</div> <div>POSTAL CODE</div> </div>			<div> <div></div> <div>PHONE NO.</div> </div>		
				<div> <div></div> <div>SIGNATURE OF SUBSCRIBER</div> </div>		

**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

[illegible]

## 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 YOUR 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. \_\_\_\_\_

2. YOUR NAME (PLEASE PRINT) \_\_\_\_\_

EMPLOYER \_\_\_\_\_

YOUR CERT. NO. OR I.D. NO. \_\_\_\_\_

NAME OF INSURING AGENCY OR PLAN \_\_\_\_\_

YOUR DATE OF BIRTH \_\_\_\_\_

DAY	MONTH	YEAR

### PART 3 - PATIENT INFORMATION

<p>1. PATIENT: RELATIONSHIP TO EMPLOYEE/ PLAN MEMBER/SUBSCRIBER _____</p> <p>DATE OF BIRTH _____ IF CHILD INDICATE: <input type="checkbox"/> STUDENT <input type="checkbox"/> HANDICAPPED  <div style="display: flex; justify-content: space-around; width: 100px;"> <span>DAY</span> <span>MONTH</span> <span>YEAR</span> </div> </p> <p>IF STUDENT, INDICATE SCHOOL _____</p> <p>PATIENT I.D. NO. _____</p>	<p>3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? IF YES, GIVE DATE AND DETAILS SEPERATELY. <input type="checkbox"/> NO <input type="checkbox"/> YES</p> <p>4. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT. <input type="checkbox"/> NO <input type="checkbox"/> YES</p> <p>5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? <input type="checkbox"/> NO <input type="checkbox"/> YES</p> <p>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.</p>
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<p>2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN, W.C.B. OR GOV'T PLAN? <input type="checkbox"/> NO <input type="checkbox"/> YES</p> <p>POLICY NO. _____ SPOUSE DATE OF BIRTH _____</p> <p>NAME OF OTHER INSURING AGENCY OR PLAN _____</p>	<p>DATE _____  <div style="display: flex; justify-content: space-around; width: 100px;"> <span>DAY</span> <span>MONTH</span> <span>YEAR</span> </div> </p> <p>_____ SIGNATURE OF EMPLOYEE/PLAN MEMBER/SUBSCRIBER</p>
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**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)