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**STANDARD DENTAL
CLAIM FORM**
APPROVED BY THE
CANADIAN DENTAL
ASSOCIATION

PART 1 DENTIST

NAME: _____
ADDRESS: _____
CITY, PROVINCE: _____
POSTAL CODE: _____
TELEPHONE: _____ SOCIAL INS. NUMBER: _____

PATIENT'S LAST NAME: _____ GIVEN NAMES: _____
ADDRESS: _____ APT: _____
CITY: _____ PROV: _____
POSTAL CODE: _____

DATE OF SERVICE			INT. TOOTH CODE	PROCEDURE CODE	TOOTH SURFACES	LABORATORY CHARGE	DENTIST'S FEE	TOTAL CHARGE
DAY	MTH	YR						

THIS IS AN ACCURATE STATEMENT OF SERVICE PERFORMED AND FEES CHARGED E & OE

TOTAL SUBMITTED FEE

DATE: _____ DAY: _____ MONTH: _____ YEAR: _____

DENTIST'S SIGNATURE: _____

FOR DENTIST'S USE ONLY FOR ADDITIONAL INFORMATION RE DIAGNOSIS PROCEDURES OR COMPLICATIONS AND SPECIAL CONSIDERATIONS.

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY POLICY BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE COST OF THE TREATMENT. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY OR ITS AGENTS.

I HEREBY ASSIGN BENEFITS | PAYABLE FROM THIS CLAIM TO THE ABOVE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO THEM.

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN): _____

SIGNATURE OF SUBSCRIBER: _____

FOR PLAN ADMINISTRATOR ONLY

	%	%	%

FOR PLAN ADMINISTRATOR ONLY

PART 2 EMPLOYEE/SUBSCRIBER Complete this part before taking to your dentist

1. PATIENT: RELATIONSHIP TO EMPLOYEE: _____ DATE OF BIRTH: _____
IF CHILD IS 19 OR OVER INDICATE STUDENT HANDICAPPED

2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN?
NO YES
POLICY NUMBER: _____
NAME OF INSURING AGENCY: _____

3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? NO YES

4. IS ANY TREATMENT FOR ORTHODONTIC PURPOSES? NO YES

5. IS THIS DENTURE, CROWN OR BRIDGE
THE ORIGINAL INSERTION IF REPLACEMENT,
A REPLACEMENT GIVE A DATE OF ORIGINAL INSERTION: _____
REASON FOR REPLACEMENT: _____

6. I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO THE INSURER OR ITS AGENTS AND CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

7. EMPLOYEE NAME: _____ DATE OF BIRTH: _____
ADDRESS: _____
DATE (DAY/MTH/YR): _____ SIGNATURE: _____

PART 3 POLICY HOLDER

1. GROUP NUMBER: MCP-5800

2. NAME OF EMPLOYEE: _____

3. CERT. NO.: _____

4. IS CLAIM BEING MADE FOR WORKMEN'S COMPENSATION BENEFITS?
NO YES

THIS PORTION TO BE COMPLETED BY SELF ACCOUNTING POLICY HOLDERS ONLY

5. S.I.N.: _____

6. EMPLOYEE CLASS:

	DAY	MONTH	YEAR
7. DATE INSURED:			
8. DATE DEPENDENT INSURED:			
9. DATE TERMINATED: (IF APPLICABLE)			
10. NAME OF POLICY HOLDER AUTHORIZED SIGNATURE:			
DATE (DAY/MONTH/YEAR):			

PART 4 SPOUSE DATA (MUST BE COMPLETED IF CLAIM IS FOR SPOUSE OR CHILD)

1. SPOUSE'S NAME (FIRST, MIDDLE & LAST): _____

2. SPOUSE'S SOCIAL SECURITY NUMBER: _____

3. SPOUSE'S DATE OF BIRTH: _____

4. SPOUSE'S EMPLOYER'S NAME: _____

5. SPOUSE'S EMPLOYER'S ADDRESS: _____

6. SPOUSE'S EMPLOYER'S AREA CODE & PHONE NUMBER: _____