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

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

DENTIST'S SIGNATURE

TOTAL SUBMITTED FEE

DATE | DAY | MONTH | YEAR

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 IINFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY OR ITS AGENTS.

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN)

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

SIGNATURE OF SUBSCRIBER

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
   ☐ A REPLACEMENT
   IF 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:

ALL INFORMATION ON THIS FORM IS CONFIDENTIAL