



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 _____ SIGNATURE OF SUBSCRIBER
PATIENT		DENTIST PHONE NO.			
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		

DATE OF SERVICE DAYMO.YR.			PRO- CEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES					
									FOR CARRIER USE				
									ALLOWED AMOUNT	INC	%	PATIENT'S SHARE	
									CHEQUE NO.			DATE	
									DEDUCTIBLE	PATIENT PAYS		PLAN PAYS	
CLAIM NO.													
THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE.						TOTAL FEE SUBMITTED							

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

1. PATIENT: RELATIONSHIP TO EMPLOYEE/ PLAN MEMBER/SUBSCRIBER _____ DATE OF BIRTH _____ IF CHILD INDICATE: ☐ STUDENT ☐ HANDICAPPED DAY MONTH YEAR IF STUDENT, INDICATE SCHOOL _____ PATIENT I.D. NO. _____	3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? IF YES, GIVE DATE AND DETAILS SEPERATELY. ☐ NO ☐ YES
2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN, W.C.B. OR GOV'T PLAN? ☐ NO ☐ YES POLICY NO. _____ SPOUSE DATE OF BIRTH _____ DATE _____ DAY MONTH YEAR	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 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.
NAME OF OTHER INSURING AGENCY OR PLAN _____	_____ SIGNATURE OF EMPLOYEE/PLAN MEMBER/SUBSCRIBER

PART 4. - POLICY HOLDER/EMPLOYER (FOR COMPLETION ONLY IF APPLICABLE. SEE ABOVE*)

1. DATE COVERAGE COMMENCED	DAY	MONTH	YEAR	4. CONTRACT HOLDER	DATE						AUTHORIZED SIGNATURE	
2. DATE DEPENDENT COVERED												
3. DATE TERMINATED						DAY	MONTH		YEAR		(POSITION OR TITLE)	