

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 authorize payment directly to him/her.
P A T I E N T	Patient Last Name	Given Name	P R O V I D E R Phone No _____			
	Address	Apt.				
	City	Province	Postal Code			

For provider's use only - for additional information, diagnosis, procedures, or special consideration.	<p>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.</p> <p>I also authorize the communication of information related to the coverage of services described in this form to the named provider.</p> Signature of Patient (Parent/Guardian) _____
Duplicate Form <input type="checkbox"/>	

Date of Service	Procedure Code	Int'l Tooth Code	Tooth Surfaces	Provider's Fee	Laboratory Charge	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 claim 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	
Last Name		Given Names		- 0 0	
				Yr	Mo Day

PART 3 - PATIENT INFORMATION					
Patient's Name (Please Print)		Patient's Identification Number		Patient's Date of Birth	
Last Name		Given Names		-	
				Yr	Mo Day
1. Patient: Relationship to Plan Member _____ If child indicate: Student <input type="checkbox"/> Handicapped <input type="checkbox"/> If student, indicate school _____			3. Is any treatment required as the result of an accident? If Yes, give date and details separately. No <input type="checkbox"/> Yes <input type="checkbox"/>		
2. Are any dental benefits or services provided under any other group insurance or dental plan, W.S.I.B. or Government Plan? No <input type="checkbox"/> Yes <input type="checkbox"/>			4. If denture, crown or bridge, is this initial placement? Give date of prior placement and reason for replacement. No <input type="checkbox"/> Yes <input type="checkbox"/>		
If Yes, Policy No. _____ Spouse Date of Birth _____ Name of other Insuring Agency or Plan _____			5. Is any treatment required for orthodontic purposes? No <input type="checkbox"/> Yes <input type="checkbox"/>		
All information recorded on this form is confidential.			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.		Signature of Plan Member _____ Date _____ Day Month Year

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 dependants, 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 dependants to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder.