DENTURIST CARE CLAIM FORM

DENTURIST SERVICES

PATIENT		DENTURIST ID:		I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM AND AUTHORIZE PAYMENT DIRECTLY TO THE NAMED DENTURIST
LAST NAME	FIRST NAME			
ADDRESS	APT. NO.			SIGNATURE OF SUBSCRIBER
CITY	PROVINCE			
POSTAL CODE	TELEPHONE NO.	DATE SUBMITTED D / M / Y	AUTHORIZATION NO.	

PATIENT INFORMATION	EMPLOYEE'S INFORMATION
BIRTHDATE D / M / Y RELATIONSHIP TO EMPLOYEE PLAN MEMBER ☐ SPOUSE ☐ SON ☐ DAUGHTER ☐ SELF	INSURANCE COMPANY
IS THIS PATIENT COVERED UNDER ANOTHER CONTRACT PROVIDING DENTAL CARE ☐ YES ☐ NO *IF YES, NAME OF INSURER GROUP NO. / POLICY NO. / PLAN NO.	GROUP/POLICY NO.
	DIVISION/SECTION NO. CERTIFICATE NO.
	LAST NAME FIRST NAME
DATE OF BIRTH (SPOUSE) D / M / Y PROSTHESIS ☐ INITIAL ☐ REPLACEMENT	BIRTH DATE D / M / Y
DATE OF EXTRACTIONS D / M / Y IF PATIENT HAS EXISTING APPLIANCE WHEN WAS IT PLACED D / M / Y	HOME PHONE ( ) BUSINESS PHONE ( )
ARE SERVICES REQUIRED AS A RESULT OF AN ACCIDENT? IF YES ATTACH DETAILS ☐ YES ☐ NO	ADDRESS (IF DIFFERENT THAN PATIENT'S)
IS A CLAIM BEING MADE FOR WORKPLACE SAFETY & INSURANCE BOARD BENEFITS? ☐ YES ☐ NO	EMPLOYER'S NAME

DATE SERVICE COMPLETED D / M / Y	PROCEDURE CODE	DESCRIPTION OF SERVICE	DENTURIST CLINICAL FEE	LABORATORY CHARGES	TOTAL CHARGES

****DENTURIST USE ONLY****

ADDITIONAL INFORMATION

☐ **FOR PRE-AUTHORIZATION ONLY**

MARK TEETH BEING REPLACED BY PARTIAL DENTURE

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	

THIS IS AN ACURATE STATEMENT OF SERVICES PREFORMED AND TOTAL FEES DUE AND PAYABLE EXCEPT ERROS AND OMISSIONS.

TOTAL FEE CLAIMED

DENTURIST'S SIGNATURE / OFFICE STAMP

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 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 ANY ADDITIONAL INFORMATION REQUIRED WITH RESPECT TO THIS CLAIM TO MY INSURANCE COMPANY / PLAN ADMINISTRATOR. I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED TO THE COVERAGE OF SERVICES DESCRIBED IN THIS FORM TO THE NAMED DENTURIST.

SIGNATURE OF PATIENT (PARENT/GUARDIAN) DATE (D/M/Y)

COMPLETED BY EMPLOYER

EFFECTIVE DATE	D	M	Y
INDIVIDUAL			
FAMILY			
DATE OF EMPLOYMENT			
TERMINATION			

CLASS

SIGNATURE

TITLE DATE

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL