



**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
P A T I E N T	FIRST NAME _____	LAST NAME _____		D E N T I S T	
	ADDRESS _____	APT. _____			
CITY _____ PROV. _____ POSTAL CODE _____		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			PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES
DAY	MO.	YR.						

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. _____
 EMPLOYER _____
 NAME OF INSURING AGENCY OR PLAN _____

2. YOUR NAME (PLEASE PRINT) _____
 YOUR CERT. NO. OR S.I.N. OR I.D. NO. _____
 YOUR DATE OF BIRTH _____ DAY MONTH YEAR

PART 3 - PATIENT INFORMATION

1. PATIENT: RELATIONSHIP TO EMPLOYEE/PLAN MEMBER/SUBSCRIBER _____
 DATE OF BIRTH _____ DAY MONTH YEAR IF CHILD INDICATE: STUDENT HANDICAPPED
 IF STUDENT, INDICATE SCHOOL _____
 PATIENT I.D. NO. _____

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 _____
 NAME OF OTHER INSURING AGENCY OR PLAN _____

3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? NO YES
 IF YES, GIVE DATE AND DETAILS SEPERATELY.
 4. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? NO YES
 GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT.
 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.
 DATE _____ DAY MONTH YEAR

 SIGNATURE OF EMPLOYEE/PLAN MEMBER/SUBSCRIBER

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

1. DATE COVERAGE COMMENCED 2. DATE DEPENDENT COVERED 3. DATE TERMINATED	<table border="1" style="border-collapse: collapse; text-align: center;"> <tr><th>DAY</th><th>MONTH</th><th>YEAR</th></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </table>	DAY	MONTH	YEAR										4. CONTRACT HOLDER <table border="1" style="border-collapse: collapse; text-align: center;"> <tr><th>DAY</th><th>MONTH</th><th>YEAR</th></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </table>	DAY	MONTH	YEAR										DATE _____ _____ AUTHORIZED SIGNATURE _____ (POSITION OR TITLE)
DAY	MONTH	YEAR																									
DAY	MONTH	YEAR																									