



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 authorized payment directly to him/her				
P A T I E N T	Patient Last Name Given Name	Address Apt.		P R O V I D E R	Phone No						Signature of Plan Member
	City	Prov.	Postal Code								
For provider's use only - for additional information, diagnosis, procedures, or special consideration.				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. I also authorize the communication of information related to the coverage of services described in this form to the named provider. Signature of Patient (Parent/Guardian) _____							
Duplicate Form <input type="checkbox"/>				Office Verification							
Date of Service DAY MO YR.	Procedure Code	Int'l Tooth Code	Tooth Surfaces	Provider's Fee	Laboratory Charges	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 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		-00	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 _____		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"/>	
If child, indicate: Student <input type="checkbox"/> Handicapped <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 student, indicate school _____		5. Is any treatment required for orthodontic purposes? 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"/>		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.	
If Yes, Policy No. _____ Spouse Date of Birth _____		Date _____	
Name of other insuring Agency or Plan _____		Day Month Year	
All information recorded on this form is confidential.		Signature of Plan Member _____	

I am authorized by my spouse and/or dependents to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder. By signing this claim form and/or submitting actual receipts, I agree that the information provided is complete and accurate. I understand that the information provided by me to Green Shield Canada about myself and my dependents, 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 further authorize Green Shield Canada to obtain and exchange information with other parties, such as health practitioners or insurers, in order to confirm the accuracy of the submitted claim(s) information. In the event of suspected fraudulent activity pertaining to claims submitted on behalf of myself and/or my dependents, I acknowledge and agree to the disclosure of this information to relevant parties, such as the Plan Sponsor, regulatory and law enforcement agencies.