

Dental Claim Form

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|-------------------------|-------------------------|---|
| Part 1 – Dentist | | Policy No.: _____ |
| Unique No. _____ | Spec. _____ | Patient's Office Account Number _____ |
| Patient's Name _____ | Dentist's Name _____ | I hereby assign any benefits payable from this claim to the named dentist and authorize payment directly to him/her. Signature of Subscriber _____ |
| Address _____ | Address _____ | |
| Telephone No: () _____ | Telephone No: () _____ | |

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|---|---|
| For Dentist use only <input type="checkbox"/> Duplicate form (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 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. Signature of patient (parent / guardian) _____ <input type="checkbox"/> Office Verification _____ |
|---|---|

| | | | | | | | For Carrier Use : | | | |
|--|----------------|------------------|----------------|----------------|--------------------|---------------|--|--------------|--------------------|-----------------|
| Date of Service (D/M/Y) | Procedure Code | Intl. Tooth Code | Tooth Surfaces | Dentist's Fees | Laboratory Charges | Total Charges | Allowed Amount | Inc. | % | Patient's Share |
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| | | | | | | | Cheque No. _____ | | Date (D/M/Y) _____ | |
| | | | | | | | Deductible | Patient Pays | Plan Pays | |
| This is an accurate statement of services performed and the total fee due and payable, E & OE. | | | | | | | Total Fee Submitted : \$ _____ | | Claim Number _____ | |

Part 2 – Dentist's Supplementary Report

1. Description of damage _____

2. Is further treatment indicated? Yes No If Yes, please indicate :

| Intl. Tooth Code | Treatment Indicated – use procedure code if possible | Estimated Date – Treatment (D/M/Y) |
|------------------|--|------------------------------------|
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3. Describe further potential problems and indicate time frame. _____

4. A) How many teeth were involved? _____ B) Were these whole or sound teeth? Yes No
 C) How many of these teeth had fillings? _____ D) How many of these injured teeth had crowns? _____
 E) How many of these teeth had root canal treatment? _____
 F) If not whole or sound teeth, explain reason why _____

Dentist's Signature _____ Date D M Y