



P. O. BOX 1608 Windsor, Ontario N9A 7G1
Attn: Dental Department or Customer Service Centre 1-888-711-1119

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>P Patient Last Name Given Name A Address Apt. T City Prov. Postal Code I Phone No E Signature of Plan Member N Signature of Patient (Parent/Guardian) T</p>								
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	
		Yr Mo Day	
		-00	
Last Name	Given Names		

PART 3 - PATIENT INFORMATION	
Patient's Name (Please print)	Patient's Identification Number
Last Name	Given Names
1. Patient: Relationship to Plan Member _____	
If child, indicate: Student <input type="checkbox"/> Handicapped <input type="checkbox"/>	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 student, indicate school _____	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"/>
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"/>	5. Is any treatment required for orthodontic purposes? No <input type="checkbox"/> Yes <input type="checkbox"/>
If Yes, Policy No. _____ Spouse Date of Birth _____	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.
Name of other insuring Agency or Plan _____	Signature of Plan Member _____
Date _____	
Day Month Year	
All information recorded on this form is confidential.	
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.	