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

Signature of Plan Member

PATIENT

Patient Last Name Given Name

Address Apt.

City Prov. Postal Code

PROVIDER

Phone No

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 ☐

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 reimbursment.

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** -00 **Plan Member's Date of Birth** Yr Mo Day

Last Name **Given Names**

PART 3 - PATIENT INFORMATION

Patient's Name (Please print) **Patient's Identification Number** -- **Patient's Date of Birth** Yr Mo Day

Last Name **Given Names**

1. Patient: Relationship to Plan Member_____

If child, indicate: Student ☐ Handicapped ☐

If student, indicate school_____

2. Are any dental benefits or services provided under any other group insurance or dental plan, W.S.I.B. or Government plan? No ☐ Yes ☐

If Yes, Policy No._____ Spouse Date of Birth_____

Name of other insuring Agency or Plan_____

All information recorded on this form is confidential.

3. Is any treatment required as the result of an accident? if Yes, give date and details separately. No ☐ Yes ☐

4. If denture, crown or bridge, is this initial placement? Give date of prior placement and reason for replacement. No ☐ Yes ☐

5. Is any treatment required for orthodontic purposes? No ☐ Yes ☐

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.

_____ Date_____

Signature of Plan Member Day Month Year

By signing this claim form and/or submitting actual receipts, I agree that the information provided on this form 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 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.