DENTURIST ASSOCIATION OF BRITISH COLUMBIA

STANDARD DENTAL CLAIM FORM

PART 1 DENTURIST

DENTURIST'S PAYMENT NO.	SPEC.	PATIENT'S OFFICE ACCOUNT NO.

THEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTURIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER

SIGNATURE OF SUBSCRIBER

PATIENT

DENTURIST

FOR DENTURIST'S USE ONLY - FOR ADDITIONAL INFORMATION, USE DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION

DUPLICATE FORM ☐

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 DENTURIST 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)

DENTURIST SIGNATURE - I CERTIFY THAT THE SERVICES HAVE BEEN PERFORMED

DATE OF SERVICE MO. DAY. YR.	PRO-CEDURE CODE	INTL TOOTH CODE	ARCH CODE	DENTURIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE.

TOTAL FEE SUBMITTED

FOR CARRIER USE

ALLOWED AMOUNT	INC	%	PATIENT'S SHARE

CHEQUE NO.	DATE

DEDUCTIBLE	PATIENT PAYS	PLAN PAYS

CLAIM NO.

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
MO. DAY YEAR

PART 3 - PATIENT INFORMATION

1. PATIENT: RELATIONSHIP TO EMPLOYEE/ PLAN MEMBER/ SUBSCRIBER

DATE OF BIRTH

IF AGE 21 OR OVER, INDICATE

STUDENT ☐ HANDICAPPED ☐

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 SEPARATELY.

4. IF DENTURE; IS THIS INITIAL PLACEMENT? NO ☐ YES ☐

5. 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
MO. DAY YEAR

SIGNATURE OF EMPLOYEE/PLAN MEMBER/SUBSCRIBER

PART 3 - POLICY HOLDER/EMPLOYER (FOR COMPLETION ONLY IF APPLICABLE. SEE ABOVE*)

	DAY	MONTH	YEAR
1. DATE COVERAGE COMMENCED			
2. DATE DEPENDENT COVERED			
3. DATE TERMINATED			

4. CONTRACT HOLDER

DATE		
DAY	MONTH	YEAR

AUTHORIZED SIGNATURE

(POSITION OR TITLE)

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL