claimsecure

DENTAL CLAIM FORM

STUDENTASSOCIATION GEORGE BROWN COLLEGE

PART 1 – DENTIST

UNIQUE NO. ❑ SPEC. ❑ PATIENT'S OFFICE ACCOUNT NO.

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER

PATIENT

DENTIST

PHONE NO.

SIGNATURE OF SUBSCRIBER

FOR DENTIST'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 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. I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED TO THE COVERAGE OF SERVICES DESCRIBED IN THIS FORM TO THE NAMED DENTIST AND THE PLAN MEMBER.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

DUPLICATE FORM ❑

OFFICE VERIFICATION/DENTIST'S SIGNATURE

DATE OF SERVICE			PROCEDURE CODE	INT'L TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES	FOR CARRIER USE			
DAY	MO.	YR.							ALLOWED AMOUNT	INC.	%	PATIENT'S SHARE
									CHEQUE NO.		DATE	
									DEDUCTIBLE	PATIENT PAYS		PLAN PAYS
THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & O.E.					TOTAL FEE SUBMITTED				CLAIM NO.			

PART 2 – EMPLOYEE / PLAN MEMBER / SUBSCRIBER

1. GROUP POLICY / PLAN NO. 510000 DIVISION / SECTION NO. _____

2. YOUR NAME (PLEASE PRINT) _____

INSTITUTION George Brown College

STUDENT IDENTIFICATION NUMBER _____ GBC

NAME OF INSURING AGENCY OR PLAN _____

YOUR DATE OF BIRTH _____
DAY MONTH YEAR

PART 3 – PATIENT INFORMATION

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

DATE OF BIRTH _____
DAY MONTH YEAR

IF CHILD, INDICATE STUDENT ❑ HANDICAPPED ❑

IF STUDENT, INDICATE SCHOOL _____

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? IF YES, GIVE DATE AND DETAILS ❑ 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

6. 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 _____
DAY MONTH YEAR

SIGNATURE OF EMPLOYEE / PLAN MEMBER / SUBSCRIBER

PART 4 – POLICY HOLDER / EMPLOYER (FOR COMPLETION ONLY IF APPLICABLE, SEE ABOVE*)

	DAY	MONTH	YEAR	CONTRACT HOLDER	DAY	MONTH	YEAR
1. DATE COVERAGE COMMENCED							
2. DATE DEPENDENT COVERED							
3. DATE TERMINATED(POSITION OR TITLE)							

AUTHORIZED SIGNATURE

ClaimSecure, PO Box 6500, STN A Sudbury,ON P3A 5N5