SUBMIT TO:
6 CUMBERLAND STREET, BARRIE, ON L4N 2P4
TOLL FREE (800) 661-9023
PHONE (705) 734-6279
FAX (705) 734-9725

STANDARD DENTAL CLAIM FORM

PART 1: DENTIST	UNIQUE #	SPEC	PATIENT ACCOUNT
PATIENT	DENTIST		

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

SIGNATURE OF SUBSCRIBER

FOR DENTIST'S USE ONLY – FOR ADDITIONAL INFORMATION, DIAGNOIS, PROCEDURES OR SPECIAL CONSIDERATION

DUPLICATE FORM _____

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED 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 RENEDERED. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY / PLAN ADMINISTRATOR.

_____
SIGNATURE OF PATIENT (PARENT/GUARDIAN)

DATE DAY	DATE MO	DATE YR	PROCEDURE CODE	INTERNAL TOOTH CODE	TOOTH SURFACE	LAB CHARGES	TOTAL CHARGES

FOR ADJUDICATOR USE

ALLOWED AMOUNT	INC	%	PATIENT 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 & OE.

TOTAL FEE SUBMITTED:

CLAIM NO.

PART 2 – EMPLOYEE / PLAN MEMBER / SUBSCRIBER

1 GROUP POLICY / PLAN NO.
EMPLOYER
NAME OF INSURING AGENCY OR PLAN

2 NAME
CERT/SIN/ID NO.
DATE OF BIRTH (D/M/YR)

PART 3 – PATIENT INFORMATION

1 PATIENT: RELATIONSHIP TO EMPLOYEE / PLAN MEMBER / SUBSCRIBER

DATE OF BIRTH (D/M/YR)

IF CHILD INDICATE: STUDENT _____ HANDICAPPED _____

IF STUDENT, INDICATE SCHOOL:

PATIENT ID NO.

2 ARE ANY 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 INSURANCE AGENCY OR PLAN

		NO	YES
	HAVE ANY OF THESE PROCEDURES BEEN SUBMITED TO ANY OTHER GROUP PLAN OR GOVERNMENT PLAN FOR PAYMENT?		
	IF YES, HAVE YOU ATTACHED A COPY OF THE EXPLANATIOJN OF BENEFITS TO THIS CLAIM FORM?		
3	IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? IF YES GIVE DETAILS SEPERATELY.		
4	IF DENTURE, CROWN OR BRIDGE, IS THIS THE INITIAL PLACEMENT? GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT.		
5	IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES?		
6	**WOULD YOU LIKE ANY UNPAID BALANCE TO BE PAID FROM YOUR HEALTH SPENDING ACCOUNT / COST PLUS (IF APPLICABLE)**?		

PART4 - AUTHORIZATION AND SIGNATURE

I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN REPSECT 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. THE CLAIM INFORMATION WILLINGLY PROVIDED BY ME TO SKIPWITH & ASSOCIATES INSURANCE AGENCY INC. HELD IN THEIR FILE WILL BE USED BY SKIPWITH & ASSOCIATES INSURANCE AGENCY INC. FOR THE PURPOSES OF CLAIMS PROCESSING AND ADJUDICATION. I UNDERSTAND AND AUTHORIZE THAT FOR THE ABOVE PURPOSES THE PERSONAL INFORMATION ON FILE IS ACCESSIBLE TO, AND MAY BE EXCHANGED WITH, AUTHORIZED EMPLOYEES OF AND RELEVANT THIRD PARTIES RETAINED BY SKIPWITH & ASSOCIATES INSURANCE AGENCY INC., ITS SALES DISTRIBUTION NETWORK, PARTICIPATING RE-INSURER (S), OTHER INSURANCE COMPANIES, INVESTIGATIVE ORGANIZATIONS, HEALTH CARE PROVIDERS, INCLUDING, BUT NOT LIMITED TO, PHARMACIES, PYSICIANS, DENTISTS, AND ANY OTHER PERSON OR PARTY WHOM I AUTHORIZE. IF APPLYING FOR MY SPOUSE AND/OR DEPENDENTS, I CONFIRM THAT I AM AUTHORIZED TO ACT ON THEIR BEHALF AND THEREFORE THIS CONSENT AND AUTHORIZATION LSO APPLIES TO THE COLLECTION, USE AND COMMUNICATION OF THEIR PERSONAL INFORMATION FOR THE SAME PURPOSES. I UNDERSTAND THAT CLAIMS MADE UNDER THE GROUP POLICY ARE SUBMITED THROUGH ME AS THE PLAN MEMBER. I THEREFORE AUTHORIZE SKIPWITH & ASSOCIATES INSURANCE AGENCY INC. TO EXCHANGE INFORMATION ABOUT THESE CLAIMS WITH ME OR ANY PERSON ACTING ON MY BEHALF, INCLUDING A SPOUSE OR DEPENDENT, AS DEEMED NECESSARY FOR THE PURPOSE OF CONFIRMING ELIGIBILITY AND ASSESSING AND MANAGING THE CLAIM.

_____ _____
SIGNATURE OF EMPLOYEE / PLAN MEMBER / SUBSCRIBER DATE (DD/MM/YYYY)