GroupSource
Suite 200, 5970 Centre Street SE
Calgary, AB T2H 0C1
Phone: (403) 228-1644
Toll Free: 1-866-862-5246
Fax: (403) 228-1775

STANDARD DENTAL CLAIM FORM

PART 1 - DENTIST

PATIENT
Last Name _____ Given Name _____
Address _____ Apt. _____
City _____ Prov. _____ Postal Code _____

DENTIST
Unique No. Spec Patients Office Account No.
Phone No.

I hereby assign my benefits payable from this claim to the named dentist and authorize payment directly to him / her.

_____
Signature of Employee

For dentist use only - For additional information, diagnosis, procedures or special consideration
Pre-treatment x-rays are required for estimates and claims involving major dental work

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 dentist for the entire treatment.

I acknowledge that the total fee of $ _____ is accurate and is for services rendered.

_____
Signature of Patient (parent / guardian)

DATE OF SERVICE yyyy mm dd	PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES
			TOTAL FEE			

INSTRUCTIONS FOR CLAIMS SUBMISSIONS

All parts of this form must be completed in full. If information is missing, the form may be returned to you.

1. Have the attending dentist complete Part 1
2. You complete Parts 2, 3 and 4 below

FOR CARRIER USE

This is an accurate statement of services performed and the total fee due and payable. E & OE.

_____
Office Verification / Dentist's Signature

PART 2 - PATIENT INFORMATION

1. Relationship of patient to Employee _____
Date of Birth: yyyy _____ mm _____ dd _____

2. If claim is for dependent child, is that child:
Handicapped? Yes ☐ No ☐
A Full Time Student? Yes ☐ No ☐
Name of School _____ No. of hours per week _____

3. Are dental benefits or services provided under any other insurance plan?
No ☐ Yes ☐ If yes, provide:
Policy Number _____
Name of Insurer _____
Spouse's Name _____
Spouse's Date of Birth mm _____ dd _____

4. Is any of the above work for Orthodontic purposes? Yes ☐ No ☐

5. (a) If treatment is due to an accident, indicate the date: yyyy _____ mm _____ dd _____

(b) Is a claim being made for Workers' Compensation Benefits? Yes ☐ No ☐

6. If the treatment involves the placement of a bridge, denture or crown, is this initial placement?
Upper Yes ☐ No ☐ Lower Yes ☐ No ☐

If "No" provide the previous placement date: yyyy _____ mm _____ dd _____

If initial denture or bridge, indicate dates teeth were extracted: yyyy _____ mm _____ dd _____

7. Do you want any unpaid balance from this claim reimbursed from your Health Spending Account (if applicable)? ☐ Yes ☐ No

PART 3 - EMPLOYEE INFORMATION

Policy Number	Employer Name	Employee Identification Number
Last Name	Given Name / Name Commonly Used	Gender Male ☐ Female ☐
Apt. / House #	Street Address	Date of Birth yyyy / mm / dd
City	Province / Postal Code	Daytime Tel. No. / Evening Tel. No.

PART 4 - AUTHORIZATION AND DECLARATION

I certify that the information contained herein is true, complete and accurate and that each of the listed expenses was purchased and/or incurred in connection with dental treatment of the above-named individuals. I acknowledge that the submission of false or incomplete information may result in the delay or denial of this claim. I authorize any physician, dentist or any health care provider and/or facility, any insurance company, benefit service provider and any other person or organization having any medical or other relevant personal information regarding me or my spouse and/or dependant to release to and exchange with the insurer, the group plan administrator or their representatives and/or agents any and all information necessary to investigate and confirm the accuracy and validity of this claim, determine eligibility for benefits and/or administer the claim and group benefit plan. I confirm that I am authorized to act on behalf of my spouse and/or dependents for such purposes. **Any copy of this Authorization and Declaration shall be as valid as the original.**

Original Employee Signature is required on all claim forms

Employee Signature _____ **Date** _____

Sign only if mandated by Administrative Services Only (ASO) arrangement:

Employer Signature _____ **Date** _____