



Dental Claim Form

A To be completed by dentist

PATIENT	Last Name _____	Given Name _____	DENTIST	Unique # _____	Spec. _____	Patient's Office Account # _____	I hereby assign my benefits payable from this claim to the named dentist and authorize payment directly to him / her. _____ Signature of subscriber	
	Address _____	Apt. _____		Phone #: _____				
	City _____	Province _____		Postal Code _____				
For Dentist Use Only - For additional information, diagnosis, procedures or special consideration. Duplicate form <input type="checkbox"/>			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. _____ Signature of Student					

Date of Service			Procedure Code	Intl. Tooth Code	Tooth Surfaces	Dentist's Fee	Lab Charges	Total Charges	Office Use Only				
									Allowed Amt.	Inc.	Percentage	Patient's Share	
D	M	Y											

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

Dentist's Signature _____	Date (dd/mm/yyyy) _____	Total Fee Submitted _____	Cheque # _____	Date _____
			Deductable _____	Patient Pays _____
			Plan Pays _____	
			Claim # _____	

B Information about Policy Holder - Policy holder is uOttawa student who has paid dental fees.

Please be sure to fully complete this section using block letters Use your uOttawa student number as your certificate number. Please be sure to write your full name and date of birth.

Group #	1480	Certificate #	_ _ _ _ _ _ _ _ _ _ O T T	Employer, Union, or School Name	SFUO
First Name	Last Name		Date of Birth (dd/mm/yy)		
Name of Insurance Company		Assumption Life			

C Information about claim

State your relationship to the patient (ex. spouse). If the patient is your child fill out the second box. If you are covered by another dental plan (ex. from your spouse or parent) fill out the third box. Answer all subsequent questions.

Patient Name	Relationship to Policy Holder	Patient Date of Birth (dd/mm/yyyy)
If patient is child of policy holder: student? <input type="checkbox"/> disabled? <input type="checkbox"/>		
If student please indicate school		Patient ID #

Are any dental benefits provided under any other group insurance or dental plan? Yes No

Authorizing Signature

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.

 Signature of student

 Date

Other Policy #	Name of other insuring agency or plan	Spouse Date of Birth (dd/mm/yyyy)
Is any treatment required as the result of an accident? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes attach details, including the date, to this claim.		
If denture, crown, or bridge, is this initial placement? Yes <input type="checkbox"/> No <input type="checkbox"/> Give date of prior placement and reason for replacement.		
Is any treatment required for orthodontic purposes? Yes <input type="checkbox"/> No <input type="checkbox"/>		

D Mailing Instructions - mail your claim with original receipts to the address below.

Assumption Life
P.O. Box 160, 770 Main Street
Moncton, New Brunswick, E1C 8L1



Assumption Life