PO Box 1608, Windsor, Ontario N9A 7G1
Attn: Dental Department or CUSTOMER SERVICE CENTRE 1-888-711- 1119

DENTAL CLAIM FORM

PART 1 - PROVIDER

PATIENT

Patient Last Name | Given Name

Address | Apt.

City | Province | Postal Code

PROVIDER

Unique No | Spec | Patient's Office Account No.

Phone No

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

Signature of Plan Member

For provider's use only - for additional information, 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 provider 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 provider.

Signature of Patient (Parent/Guardian) _____

Office Verification

Date of Service DAY MO YR	Procedure Code	Int'l Tooth Code	Tooth Surfaces	Provider's Fee	Laboratory Charge	Total Charges	Allowed Amount	Code

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

TOTAL FEE SUBMITTED

INSTRUCTIONS FOR CLAIM SUBMISSION

Please carefully fill in all pertinent areas and sign the completed claim form. (Refer to Green Shield Identification Card for correct patient information). Incomplete or incorrect claim forms will be returned or rejected and will result in a delay in reimbursement.

All claims must be submitted within 12 months of the date of service (unless otherwise stated in your benefit plan documentation).

PART 2 - EMPLOYEE/PLAN MEMBER

Plan Member's Name (Please Print)

Last Name | Given Names

Plan Member's Identification Number - 0 0

Plan Member's Date of Birth Yr | Mo | Day

PART 3 - PATIENT INFORMATION

Patient's Name (Please Print)

Last Name | Given Names

Patient's Identification Number -

Patient's Date of Birth Yr | Mo | Day

1. Patient: Relationship to Plan Member _____
   If child indicate: Student ☐ Handicapped ☐
   If student, indicate school _____
2. Are any dental benefits or services provided under any other group insurance or dental plan, W.S.I.B. or Government Plan?
   No ☐ Yes ☐
   If 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 separately. 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 ☐

All information recorded on this form is confidential.

I authorize the release of any information or records required in respect of this claim to insurer/plan administrator and certify that the information given is true, correct and complete to the best of my knowledge.

_____ Date _____

Signature of Plan Member | Day Month Year

By signing this claim form and/or submitting actual receipts, I agree that the information provided on this form is complete and accurate. I understand that the information provided by me to Green Shield Canada about myself and my dependants, will be used by Green Shield Canada for claims adjudication and any other services necessary in the administration of our benefits which may include the exchange of information with other parties to administer this benefit claim.
I am authorized by my spouse and/or dependants to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder.