INTEGRATED BENEFIT SERVICES
888 Regent St. S. Unit 105
Sudbury, Ontario
P3E 6C6

DENTAL PLAN CLAIM FORM

STANDARD DENTAL CLAIM FORM

CANADIAN DENTAL ASSOCIATION

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: LAST NAME | GIVEN NAME | ADDRESS | APT. | CITY | PROV. | POSTAL CODE

DENTIST: PHONE NO.

X _____ SIGNATURE OF SUBSCRIBER

FOR DENTIST'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 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.

X _____ SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION

DATE OF SERVICE Day	Mo.	Yr.	PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE.

TOTAL FEE SUBMITTED

FOR PROVIDER'S USE

	INELIGIBLE	PLAN 1	PLAN 2	PLAN 3
TOTALS				
DEDUCTIBLE				
CO-INSCE.				
PAYMENT				
			TOTAL PAYMENT	

INSTRUCTIONS FOR CLAIM SUBMISSION
If your dentist has recommended crowns and/or bridgework, or any other dental expense over $500.00 please have your dentist complete a pre-treatment plan. This treatment plan must be submitted to your plan insurer before treatment begins. You will be advised of the benefits payable based on your dental plan.
PLEASE COMPLETE in full Parts 1, 2, and 3 and mail this form, to the address listed below.

PART 2 - EMPLOYEE/PLAN MEMBER

1. Group Policy/Plan No. _____ Division/Section No. _____

S.I.N. or I.D. No. _____

Employer _____ Tel. ( ) _____

2. Your Name (Pease print) _____

Sex ☐ Male ☐ Female

Your Date of Birth Day Mo. Yr.

Address _____ (Street)

_____ (City) (Province)

Postal Code _____ Tel. ( ) _____

PART 3 - PATIENT INFORMATION

1. Relationship to Employee/Plan Member:
☐ Self ☐ Spouse ☐ Child ☐ Other, please specify _____

Patient's Date of Birth Day Mo. Yr.

If child indicate:

☐ Student School _____
☐ Handicapped Has proof of handicap been submitted? ☐ No ☐ Yes

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 If yes, please indicate:

Name of other insuring agency or plan _____

Group Policy/Plan No. _____ Spouse's Date of Birth Day Mo. Yr.

Cert. No./I.D. No. _____

3. Is any treatment required as the result of an accident? ☐ No ☐ Yes
If Yes, give date and details separately.
If Yes, is it possible that a third party is or may be liable? ☐ No ☐ Yes

4. Is this a replacement of a crown, bridge, or denture? ☐ No ☐ Yes
If yes, give date of previous placement _____
and reason for replacement _____

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 my plan provider, administrator or their agents and certify that the inforamtion given is true, correct and complete to the best of my knowledge.

X _____ Signature of Employee/Plan Member

Date Day Mo. Yr.

WHERE TO MAIL YOUR CLAIM

INTEGRATED BENEFIT SERVICES
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Sudbury, Ontario
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ALL INFORMATION ON THIS FORM IS CONFIDENTIAL