

**STANDARD DENTAL CLAIM FORM**

<b>PART 1: DENTIST</b>		UNIQUE #	SPEC	PATIENT ACCOUNT	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM /HER
PATIENT		DENTIST			
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 RENEDEDERED. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY / PLAN ADMINISTRATOR.  _____ <b>SIGNATURE OF PATIENT (PARENT/GUARDIAN)</b>
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DATE			PROCEDURE CODE	INTERNAL TOOTH CODE	TOOTH SURFACE	LAB CHARGES	TOTAL CHARGES	FOR ADJUDICATOR USE				
DAY	MO	YR						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. _____
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PART 2 – EMPLOYEE / PLAN MEMBER / SUBSCRIBER	
<b>1</b> GROUP POLICY / PLAN No. EMPLOYER NAME OF INSURING AGENCY OR PLAN	<b>2</b> NAME CERT/SIN/ID No. DATE OF BIRTH (D/M/YR)

PART 3 – PATIENT INFORMATION												
<b>1</b> 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.  <b>2</b> 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	HAVE ANY OF THESE PROCEDURES BEEN SUBMITTED 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?  <b>3</b> IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? IF YES GIVE DETAILS SEPERATELY. <b>4</b> IF DENTURE, CROWN OR BRIDGE, IS THIS THE INITIAL PLACEMENT? GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT. <b>5</b> IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES?  <b>6</b> <b>WOULD YOU LIKE ANY UNPAID BALANCE TO BE PAID FROM YOUR HEALTH SPENDING ACCOUNT / COST PLUS (IF APPLICABLE)?</b>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width: 50%;">No</th> <th style="width: 50%;">Yes</th> </tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>	No	Yes								
No	Yes											

PART4 - AUTHORIZATION AND SIGNATURE	
I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN REPECT 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 HEALTH ASSIST HELD IN THEIR FILE WILL BE USED BY HEALTH ASSIST 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 HEALTH ASSIST, 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 SUBMITTED THROUGH ME AS THE PLAN MEMBER. I THEREFORE AUTHORIZE HEALTH ASSIST 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)