



## STANDARD DENTAL CLAIM FORM

₩ <sub>TM</sub>	IISUFAIICE ASSOCIATION INC	•			0_,		
PART 1 DENTIST	UNIQUE NO.   S	PEC. PATIENTS OFFIC	E ACCOUNT NO.	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT TO HIM/HER			
P A T I E N T	D Dr. Christa OI N 15 Hebron Wa T St. John's, NL S PHONE NO. (709)	ay, 3rd Floor A1A 0M1			SIGNATURE OF S	UIRSCRIRFR	
FOR DENTIST LISE ONLY - FOR ADDITIONAL INFORMATION DIAGNOSIS PR	OCENIURES OR SPECIAL CONSIDERATIONS	SIGNATURE OF SUBSCRIBER  I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY PLAN					
FOR DENTIST USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATIONS  PLEASE COMPLETE HIGHLIGHTED AREAS  BEFORE SUBMITTING TO YOUR INSURANCE		BENEFITS. I UNDERSTAND I ACKNOWLEDGE THAT TH SERVICES RENDERED. I AUTHORIZE RELEASE OF PLAN ADMINISTRATOR. I A	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 FOF 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 DENTIST.  SIGNATURE OF PATIENT (PARENT/GUARDIAN)				
DATE OF SERVICE PRO- INTL.	DENTIOTIO LABORATORI			2 10			
CODE CODE SURFACES	DENTIST'S LABORATOR' FEE CHARGE	TOTAL CHARGES			R CARRIER USE		
80000			ALLOWED A	MOUNT IN	IC %	PATIENT'S SHARE	
			CHEQUE NO.	E PAI	DATE TIENT PAYS	PLAN PAYS	
			DEDOCTIBE	L PA	ILMITATO	PLANTAIO	
THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE.			CLAIM NO.				
INSTRUCTIONS FOR CLAIM SUBMISSION	TOTAL FEE SUBMITTED						
BEING A STANDARD FORM, THIS FORM CANNOT INCLUDE SPECIFIC INSTR YOUR CERTIFICATE OR FROM YOUR EMPLOYER. IF YOU PLAN REQUIRES SUBMISSION DIRECTLY TO THE CARRIER, PLEASE *IF YOUR PLAN REQUIRES SUBMISSION TO YOUR EMPLOYER, PLEASE DIF PART 2 - EMPLOYEE/PLAN MEMBER/SUBSCRIBER	SEND THIS FORM WITH ONLY PARTS 1, 2 / Rect this form to your personnel off	AND 3 COMPLETED TO THE CARRIEF	R'S APPROPRIATE CLA	IMS OFFICE.			
1. GROUP POLICY/PLAN NO. DIVISION/S	SECTION NO.	2. YOUR NAME (PLEASE PRINT)					
EMPLOYER		YOUR CERT. NO. OR S.I.N. OR I.D	. NO				
NAME OF INSURING AGENCY OR PLAN		YOUR DATE OF BIRTHDA	Y MONTH YEAI				
PART 3 - PATIENT INFORMATION		UA	I WIUNIN TEA	ı			
1. PATIENT: RELATIONSHIP TO EMPLOYEE/ Plan Member/Subscriber		3. IS ANY TREATMENT REQUIRE IF YES, GIVE DATE AND DETAI		IN ACCIDENT?	□ NO [	YES	
DATE OF BIRTH IF CHILD INDIC	CATE: STUDENT HANDICAPPED	4. IF DENTURE, CROWN OR BRID GIVE DATE OF PRIOR PLACEM			□ NO [	YES	
IF STUDENT, INDICATE SCHOOL	5. IS ANY TREATMENT REQUIRE			□ NO [	YES		
PATIENT I.D. NO.		6. I AUTHORIZE THE RELEASE OF THE INSURER / PLAN ADMINIS	F ANY INFORMATION O STRATOR AND CERTIF	R RECORDS REQ	UESTED IN RESP	ECT OF THIS CLAIM TO	
2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHE PLAN, W.C.B. OR GOV'T PLAN? NO YES	N UNUUP INSUKACE UK DENTAL	COMPLETE TO THE BEST OF N	NT KNUWLEDGE.		DATE		
POLICY NO SPOUSE DATE OF BIRTH	f				DATE	MONTH YEAR	
NAME OF OTHER INSURING AGENCY OR PLAN		SIGNATURE OF EMPLOYEE/P	LAN MEMBER/SUBSCI	RIBER			
PART 4 POLICY HOLDER/EMPLOYER (FOR COMF	PLETION ONLY IF APPLICABLE	E. SEE ABOVE*)					
DAY MONTH YEAR		DATE					
1. DATE COVERAGE COMMENCED	4. CONTRACT HOLDER	5.112		AUTHORI	ZED SIGNATURE		
2. DATE DEPENDENT COVERED 3. DATE TERMINATED	DA	/ MONTH YEAR		(DOSIT	ION OR TITLE)		
v. 2				(FUOII	uit IIILE)		