

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|

According to your province of residence, please submit form to:

Quebec
Group Health and Dental Claims
PO Box 800, Station Maison de la Poste
Montreal, Quebec H3B 3K5

Ontario, Atlantic and Western Provinces
Group Health and Dental Claims
PO Box 4643, Station A
Toronto, Ontario M5W 5E3

**CLAIM FORM
DENTAL CARE IN CASE OF AN ACCIDENT**

Policy no.

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|

 Policyholder's name _____

Member's last name _____ First name _____

Certificate no. _____ Date of birth

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

 Sex: M F Language: E F

PART 1: DENTIST'S STATEMENT

| | |
|---|--|
| Patient (Last and first name) _____ _____ For dentist's use only to provide additional information, diagnosis, procedures, or special considerations: _____ _____ _____ Duplicate <input type="checkbox"/> Predetermination <input type="checkbox"/> | Dentist (Last and first name/Address/Phone no.) _____ _____ _____ _____ I hereby assign my benefits payable from this claim to the specified dentist and authorize payment directly to him/her. _____ Signature of subscriber I understand that I am responsible for the fees incurred independent of the claim and the coverage I have. I acknowledge that the total fee of \$_____ is accurate and has been charged to me for services rendered. Member's signature _____ Verification (Dentist) _____ |
|---|--|

Treatment and services rendered to the patient

| DATE OF SERVICE | | | PROCEDURE CODE | INT. TOOTH CODE | TOOTH SURFACES | DENTIST'S FEES | LABORATORY CHARGES | TOTAL CHARGES |
|-----------------|---|---|----------------|-----------------|----------------|----------------|--------------------|---------------|
| Y | M | D | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

Total fee submitted

| |
|--|
| |
|--|

NOTE - PLEASE INCLUDE THE X-RAYS TAKEN BEFORE THE TREATMENT

1. Tooth code of teeth damaged as a result of the accident: _____
2. Condition of teeth prior to the accident. (Were they sound natural teeth?) Give details: _____

3. If treatment cannot be given immediately, specify the dates and nature of future treatment(s), as well as the reason for the delay: _____

4. Additional information: _____

I hereby certify that the foregoing statements accurately describe the treatment given and fees incurred, and that the said treatment was necessary as the result of an accident.

Dentist's signature _____ Date

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

