Canadian Dental Association

Canadian Life and Health Insurance Association Inc.

STANDARD DENTAL CLAIM FORM

PART 1 DENTIST

122300000X

UNIQUE NO. 068003700 | SPEC. | PATIENT'S OFFICE ACCOUNT NO

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTISTS AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.

Please Remit Payment To Dentist (Signature on File)

SIGNATURE OF SUBSCRIBER

PATIENT
Michelle Tibbetts
1306 Normandy Crescent
Ottawa, ON K2C-0N3

DENTIST
Dr. Esther Guiot & Associates
Meriam Saboor,
99 Metcalfe St
Suite 104
Ottawa, ON K1P-6L7
PHONE NO. (613)234-0792

FOR DENTIST'S USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATIONS

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 $ 401.00 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 DENTIST.

SIGNATURE ON FILE

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION

DATE OF SERVICE DAY	MO.	YR.	PRO-CEDURE CODE	INTL. TOOTH CODE	TOOTH SUR-FACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES
17	08	2017	01202			33.00	0.00	33.00
17	08	2017	02144			47.00	0.00	47.00
17	08	2017	02601			65.00	0.00	65.00
17	08	2017	11101			35.00	0.00	35.00
17	08	2017	11113			165.00	0.00	165.00
17	08	2017	41301			56.00	0.00	56.00

FOR CARRIER USE

ALLOWED AMOUNT	INC	%	PATIENT'S SHARE

CHEQUE NO. | DATE

DEDUCTIBLE	PATIENT PAYS	PLAN PAYS

CLAIM NO.

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

TOTAL FEE SUBMITTED 401.00

INSTRUCTIONS FOR CLAIM SUBMISSION

BEING A STANDARD FORM, THIS FORM CANNOT INCLUDE SPECIFIC INSTRUCTIONS ON WHERE IT SHOULD BE SENT, DEPENDING ON WHO IS THE CARRIER FOR YOUR PLAN. YOU CAN OBTAIN DETAILS FROM EITHER YOUR PLAN BOOKLET, YOUR CERTIFICATE OR FROM YOUR EMPLOYER.
IF YOUR PLAN REQUIRES SUBMISSION DIRECTLY TO THE CARRIER, PLEASE SEND THIS FORM WITH ONLY PARTS 1, 2, AND 3 COMPLETED TO THE CARRIER'S APPROPRIATE CLAIMS OFFICE.
* IF YOUR PLAN REQUIRES SUBMISSION TO YOUR EMPLOYER, PLEASE DIRECT THIS FORM TO YOUR PERSONNEL OFFICE/PLAN ADMINISTRATOR WHO WILL COMPLETE PART 4 AND FORWARD THE FORM TO THE CARRIER.

PART 2 -- EMPLOYEE/PLAN MEMBER/SUBSCRIBER

1. GROUP POLICY/PLAN NO. 55666 DIVISION/SECTION NO. 1

2. YOUR NAME (PLEASE PRINT) Michelle Tibbetts

EMPLOYER Government

Great West Life
NAME OF INSURING AGENCY OR PLAN

YOUR CERT. NO. OR S.I.N. OR I.D. NO. CF6696942

YOUR DATE OF BIRTH 10 (DAY) 05 (MONTH) 1986 (YEAR)

PART 3 -- PATIENT INFORMATION

1. PATIENT: RELATIONSHIP TO EMPLOYEE/PLAN MEMBER/SUBSCRIBER Self

DATE OF BIRTH 10 (DAY) 05 (MONTH) 1986 (YEAR)

IF CHILD INDICATE STUDENT ☐ HANDICAPPED ☐

IF STUDENT, INDICATE SCHOOL

PATIENT I.D. NO. CF6696942-00

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 ☒

POLICY NO. 200104 SPOUSE DATE OF BIRTH 10 05 1986

NAME OF OTHER INSURING AGENCY OR PLAN Coughlin

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 ☐

6. I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT 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.

DATE 17 (DAY) 08 (MONTH) 2017 (YEAR)

SIGNATURE OF EMPLOYEE/PLAN MEMBER SUBSCRIBER

PART 4 -- POLICY HOLDER/EMPLOYER (FOR COMPLETION ONLY IF APPLICABLE. SEE ABOVE*)

	DAY	MONTH	YEAR
1. DATE COVERAGE COMMENCED			
2. DATE DEPENDENT COVERED			
3. DATE TERMINATED			

4. CONTRACT HOLDER

DATE (DAY / MONTH / YEAR)

AUTHORIZED SIGNATURE

(POSITION OF TITLE)

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

Part 3 Insuring Agency - Coughlin, ,