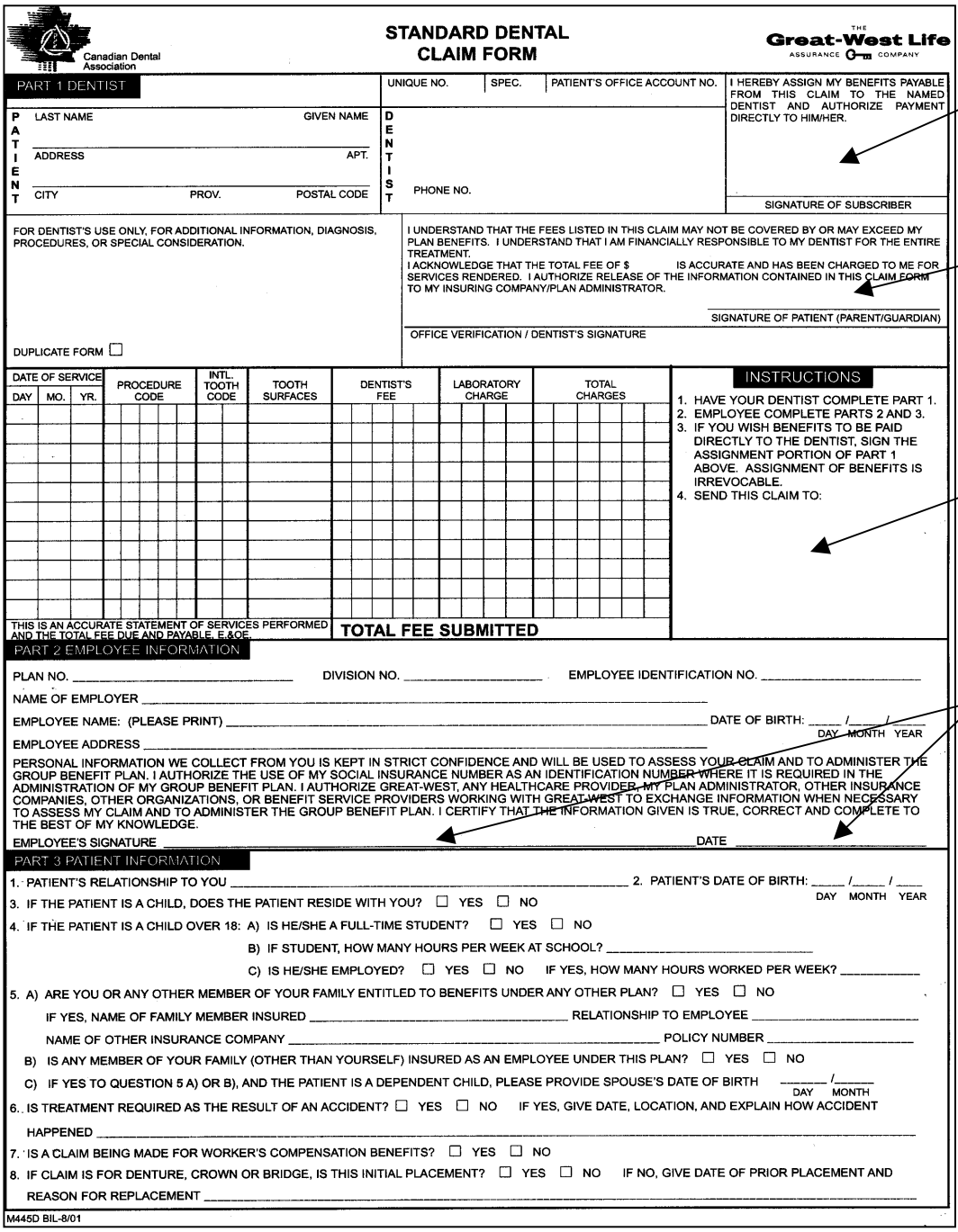
# How to complete your Dentalcare Claim Form



Canadian Dental Association

**STANDARD DENTAL CLAIM FORM**

THE Great-West Life ASSURANCE COMPANY

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.

SIGNATURE OF SUBSCRIBER

FOR DENTIST'S USE ONLY, FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION.

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.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION / DENTIST'S SIGNATURE

DUPLICATE FORM ☐

| DATE OF SERVICE DAY | MO. | YR. | PROCEDURE CODE | INTL. TOOTH CODE | TOOTH SURFACES | DENTIST'S FEE | LABORATORY CHARGE | TOTAL CHARGES |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

INSTRUCTIONS

1. HAVE YOUR DENTIST COMPLETE PART 1.
2. EMPLOYEE COMPLETE PARTS 2 AND 3.
3. IF YOU WISH BENEFITS TO BE PAID DIRECTLY TO THE DENTIST, SIGN THE ASSIGNMENT PORTION OF PART 1 ABOVE. ASSIGNMENT OF BENEFITS IS IRREVOCABLE.
4. SEND THIS CLAIM TO:

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

**TOTAL FEE SUBMITTED**

PART 2 EMPLOYEE INFORMATION

PLAN NO. _____ DIVISION NO. _____ EMPLOYEE IDENTIFICATION NO. _____

NAME OF EMPLOYER _____

EMPLOYEE NAME: (PLEASE PRINT) _____ DATE OF BIRTH: ____ /____ /____ DAY MONTH YEAR

EMPLOYEE ADDRESS _____

PERSONAL INFORMATION WE COLLECT FROM YOU IS KEPT IN STRICT CONFIDENCE AND WILL BE USED TO ASSESS YOUR CLAIM AND TO ADMINISTER THE GROUP BENEFIT PLAN. I AUTHORIZE THE USE OF MY SOCIAL INSURANCE NUMBER AS AN IDENTIFICATION NUMBER WHERE IT IS REQUIRED IN THE ADMINISTRATION OF MY GROUP BENEFIT PLAN. I AUTHORIZE GREAT-WEST, ANY HEALTHCARE PROVIDER, MY PLAN ADMINISTRATOR, OTHER INSURANCE COMPANIES, OTHER ORGANIZATIONS, OR BENEFIT SERVICE PROVIDERS WORKING WITH GREAT-WEST TO EXCHANGE INFORMATION WHEN NECESSARY TO ASSESS MY CLAIM AND TO ADMINISTER THE GROUP BENEFIT PLAN. I CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

EMPLOYEE'S SIGNATURE _____ DATE _____

PART 3 PATIENT INFORMATION

1. PATIENT'S RELATIONSHIP TO YOU _____ 2. PATIENT'S DATE OF BIRTH: ____ /____ / ____ DAY MONTH YEAR
3. IF THE PATIENT IS A CHILD, DOES THE PATIENT RESIDE WITH YOU? ☐ YES ☐ NO
4. IF THE PATIENT IS A CHILD OVER 18: A) IS HE/SHE A FULL-TIME STUDENT? ☐ YES ☐ NO
   B) IF STUDENT, HOW MANY HOURS PER WEEK AT SCHOOL? _____
   C) IS HE/SHE EMPLOYED? ☐ YES ☐ NO IF YES, HOW MANY HOURS WORKED PER WEEK? _____
5. A) ARE YOU OR ANY OTHER MEMBER OF YOUR FAMILY ENTITLED TO BENEFITS UNDER ANY OTHER PLAN? ☐ YES ☐ NO
   IF YES, NAME OF FAMILY MEMBER INSURED _____ RELATIONSHIP TO EMPLOYEE _____
   NAME OF OTHER INSURANCE COMPANY _____ POLICY NUMBER _____
   B) IS ANY MEMBER OF YOUR FAMILY (OTHER THAN YOURSELF) INSURED AS AN EMPLOYEE UNDER THIS PLAN? ☐ YES ☐ NO
   C) IF YES TO QUESTION 5 A) OR B), AND THE PATIENT IS A DEPENDENT CHILD, PLEASE PROVIDE SPOUSE'S DATE OF BIRTH ____ /____ DAY MONTH
6. IS TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? ☐ YES ☐ NO IF YES, GIVE DATE, LOCATION, AND EXPLAIN HOW ACCIDENT HAPPENED _____
7. IS A CLAIM BEING MADE FOR WORKER'S COMPENSATION BENEFITS? ☐ YES ☐ NO
8. IF CLAIM IS FOR DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? ☐ YES ☐ NO IF NO, GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT _____

M445D BIL-8/01

Have your Dentist complete Part 1 in full.

Employee is to complete these sections in full.

***Authorization***
In order for the payments to be made directly to the Dentist the **Employee** must sign here.

***Authorization***
The **Patient or Parent/Guardian** must sign here.

Mail your completed form to the office listed in your plan booklet, or as indicated by your plan administrator.

Attach all original receipts to your claim form.

***Authorization***
The **Employee** must sign and date here upon completion of this form.

Incomplete forms may be returned to you and delay processing.

Consult your plan administrator if you have any questions.