

GROUP DENTAL CLAIM FORM



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|---|---------------------------------|------------------------------|---|
| PART 1 – DENTIST | UNIQUE NO. | 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. |
| P A T I E N T Last Name _____ Given Name _____ Address _____ Apt _____ City _____ Prov _____ Postal Code _____ | D E N T I S T | PHONE NO. | |
| | Signature of Subscriber _____ | | |

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| FOR DENTIST'S USE ONLY – FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES OR SPECIAL CONSIDERATION DUPLICATE FORM <input type="checkbox"/> | I understand the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand I am financially responsible to my dentist for the entire treatment. I acknowledge that the total fees 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 | |

| Date of Service | | | PROCEDURE CODE | INT. TOOTH CODE | TOOTH SURFACES | DENTIST FEE | LABORATORY CHARGE | TOTAL CHARGES | PLEASE SUBMIT CLAIM FORM TO: Manion, Wilkins & Associates Ltd 626-21 Four Seasons Place Etobicoke ON M9B 0A6 416-234-3511 1-866-532-8999 (Toll Free) claims@manionwilkins.com _____ Plan Administrator Use Only |
|---|-----|----|----------------|-----------------|----------------|----------------------|-------------------|---------------|---|
| Day | Mo. | Yr | | | | | | | |
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| THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE E.&OE | | | | | | TOTAL FEE SUBMITTED: | | | |

PART 3 – Member complete this section (please print)

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|-----------------|-----------------|
| Plan Name: | Group Number: |
| Member Name: | Certificate No. |
| Member Address: | City / Town |
| | Prov |
| | Postal Code |

1. Do you or your dependent(s) have any other insurance to cover these benefits? Yes No If yes, please specify

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|------------------------|---------------|--------------------|
| Insurance Company Name | Policy Number | Certificate Number |
|------------------------|---------------|--------------------|

2. If denture, bridge or crown, is this an initial placement: Yes No

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| If initial placement, advise the date teeth were extracted and all other missing teeth. Date: | If replacement, advise date of prior placement and reason for replacement. Date: |
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3. If this claim is for a spouse or child, complete the following information:

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|----------------------------------|--|--|--|---|
| Dependent's Date of Birth | Relationship to Employee | Is this dependent working? | Is this dependent attending school? | If yes, give name of employer or school |
| Day _____ Month _____ Year _____ | <input type="checkbox"/> Spouse <input type="checkbox"/> Child | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

4. If treatment is due to an accident, indicate date of accident and details.

I hereby certify that the above statements are true, accurate and complete to the best of my knowledge and belief. I understand that the Plan Administrator will use the information provided by me on this claim form strictly to process my claim. I hereby authorize the Plan Administrator to evaluate or investigate my claims and release my personal information (including health information) to qualified third parties solely for the purpose of conducting such evaluations or investigations, and only to the extent required for such purposes. I understand, acknowledge, and agree that my personal information will be used in accordance with Manion's privacy policy found at <https://www.manionwilkins.com/privacy/>. I hereby authorize my union, physician, or other health professionals, any medical or dental facility, any insurance company or government body, and any other person or institutions to release relevant information to the Plan Administrator solely for the purpose of processing this claim. A photocopy of this release shall be as valid as the original.

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| Member's Signature | Date | Phone Number |
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