Green Shield CANADA

Where quality is more than a claim

DENTAL CLAIM FORM

PO Box 1608, Windsor, Ontario N9A 7G1

Attn: Dental Department (519) 739-1133 or CUSTOMER SERVICE CENTRE 1-888-711- 1119

PART 1 - PROVIDER

PATIENT

Patient Last Name | Given Name

Address | Apt.

City | Province | Postal Code

PROVIDER

Unique No | Spec | Patient's Office Account No.

Phone No

I hereby assign my benefits payable from this claim to the named provider and authorize payment directly to him/her.

Signature of Subscriber

For provider's use only - for additional information, diagnosis, procedures, or special consideration.

Duplicate Form ☐

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 provider 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

Date of Service DAY MO YR	Procedure Code	Int'l Tooth Code	Tooth Surfaces	Provider's Fee	Laboratory Charge	Total Charges	Allowed Amount	Code

This is an accurate statement of services performed and the total fee due an d payable, E & OE.

TOTAL FEE SUBMITTED

INSTRUCTIONS FOR CLAIM SUBMISSION

Please carefully fill in all pertinent areas and sign the completed claim form. (Refer to Green Shield Identification Card for correct patient information). Incomplete or incorrect claim forms will be returned or rejected and will result in a delay in reimbursement.

PART 2 - EMPLOYEE/PLAN MEMBER/SUBSCRIBER

All claims must be submitted within 12 months of the date of service.

Subscriber's Name (Please Print)

Last Name | Given Names

Subscriber's Identification Number - 0 0

Subscriber's Date of Birth Day | Mo | Yr

PART 3 - PATIENT INFORMATION

Patient's Name (Please Print)

Last Name | Given Names

Patient's Identification Number -

Patient's Date of Birth Day | Mo | Yr

1. Patient: Relationship to Subscriber _____
   If child indicate: Student ☐ Handicapped ☐
   If student, indicate school _____
2. Are any dental benefits or services provided under any other group insurance or dental plan, W.S.I.B. or Government Plan?
   No ☐ Yes ☐
   If Yes, Policy No. _____ Spouse Date of Birth _____
   Name of other Insuring Agency or Plan _____

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 ☐

I authorize the release of any information or records required in respect of this claim to insurer/plan administrator and certify that the information given is true, correct and complete to the best of my knowledge.

Signature of Subscriber **Date** _____ **Day Month Year**

All information recorded on this form is confidential.

By signing this claim form and/or submitting actual receipts, I agree that the information provided is complete and accurate, to the best of my knowledge. I authorize Green Shield Canada to exchange information with other parties as required and only when the information is needed to administer this benefit claim and/or to confirm the accuracy of this information.