

Questions about your coverage? 416-695-1799 or toll-free 1-866-424-0257



## DENTAL CLAIM FORM

	PART 1 - TO BE COMPLETED BY DENTIST LAST NAME FIRST											UNIQUE NO	. SPEC	. PA	TIENT'S NO.		
	ADDRESS																
PATIENT											DOCTAL	DENTIST					
PATI	CITY	ſ				PROV.				POSTAL		DEN	PHONE				
	FOR DENTIST'S USE ONLY - ADDITIONAL INFO, DIAGNOSIS, PROCEDURES OR SPECIAL CONSIDERATION											to the abo	ASSIGNMENT - I hereby assign my benefits payable as a result of this claim to the above named dentist and authorize payment directly to him/her. SIGNATURE OF PATIENT SIGNATURE OF PARENT/GUARDIAN DENTAL OFFICE VERIFICATION BY:				
l	SERVICE DATE PROCEDURE CODE TOOTH CODE TOOTH SURFACES DE											I DENTIST'S FEE					
			YEAR						10011	T					TREATMENT PLAN		
															WHEN A PROPOSED COST OF TREATMENT EXCEEDS \$600.00, A TREATMENT PLAN MUST BE FILED		
								_									
															WITH NEXGENRX. YOU		
								_							WILL BE ADVISED OF THE BENEFITS PAYABLE		
															UNDER YOUR PLAN BEFORE TREATMENT		
								_							BEGINS. PRE-TREAT- MENT X-RAYS ARE		
THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE. <b>TOTAL FEE SUBMITTED: \$</b>												REQUIRED FOR SOME PROCEDURES.					
<b>MAILING INSTRUCTIONS -</b> mail completed form in envelope to:																	
											The West Ma	,	Ioronto, (	Ontario M82	<u>2</u> 5M4		
	PA	R	2 -	то	B	EC	OMF	νLΕ	TED	BY EN	MPLOYEE/PLA	N MEMBER					
	CON	CONTRACT NO										MEMBER	MEMBER NAME (PRINT)				
	EMPLOYER											CERTIFIC	CERTIFICATE NUMBER				
l	ΡA	RT	3 -	PA		NT	INF	OR	MAT	ON							
I	PART 3 - PATIENT INFORMATION   1. PATIENT RELATIONSHIP TO PLAN MEMBER:											4. IF DEN MENT? IF	4. IF DENTURE, CROWN, OR BRIDGE, IS THIS INITIAL PLACE- MENT? IF YES, GIVE DATE AND DETAILS. YES NO				
		DATE OF BIRTH (DD/MM/YYYY):										5. IS THIS	5. IS THIS AN ORTHODONTIC CLAIM?				
	IF	IF CHILD INDICATE: STUDENT								DISAB	LED						
	IF STUDENT, INDICATE SCHOOL:												6. I certify that the info given above is true and complete and that I have the right to disclose personal information of my spouse and dependents				
	GF	2. DO YOU HAVE DENTAL BENEFITS UNDER ANY OTHER GROUP INSURANCE PLAN, W.C.B., OR GOV'T PLAN? ☐ YES ☐ NO INSURER NAME:										son having the above-	(if any) in connection with any claim made by me. I authorize any per- son having and personal information relevant to such claim, including the above-named dentist, NexGenRx, any insurer, administrator of any publicly or privately funded benefit plan or program, or claims auditor,				
		CONTRACT NO.										to exchang	to exchange any such personal information in connection with assess- ing any such claim and/or administering my benefit plan.				
		SPOUSE'S BIRTHDATE:										- ing any su	ng any such dann and/or administening my benefit plan.				
3. IS ANY TREATMENT REQUIRED AS A RESULT OF AN ACCI- DENT? IF YES, GIVE DATE AND DETAILS. YES NO Signature of plan member											ember	Date (DD/MM/YYYY)					