

StudyWell Benefits

DENTAL SERVICE PROVIDER

P A T I E N T	Name (Last, First)			P R O V I D E R	Unique No.	Specialty	Patient's Office Acc't No.	I hereby assign my benefits payable from this claim to the named dentist and authorize payment directly to him/her. _____ Signature of Student
	Address				Name/Address			
	City	Province	Postal Code		Telephone Number			

For Dentist Use Only – For additional information, diagnosis, procedure, or special consideration. Was this emergency treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes – If yes, please provide additional details	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 the Administrator. _____ Signature of Patient (Parent/Guardian) Office Verification:
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If charges exceed \$300.00, your claim should be submitted for predetermination of benefits.

Date of Service (MM/DD/YY)	Procedure Code	Tooth Code	Tooth Surfaces	Dentist's Fee	Laboratory Charge	Total Charges

Failure to provide procedure codes may result in a delay of processing this claim.	Total fee Submitted
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PATIENT INFORMATION

1. Patient: Relationship to Student: _____ Date of Birth: _____ If Child, please indicate <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Disabled If student, indicate school attending: _____ Date enrolled: _____ Date Completed: _____ 2. Are any dental benefits or services provided under any other group insurance, or dental plan, W.C.B. or government plan? <input type="checkbox"/> No <input type="checkbox"/> Yes – If Yes, attach co-insurance statement. If this claim is for a child, please indicate spouse's date of birth: _____	Complete this section before taking the form to your dentist's office 3. Is the treatment result of an accident, occupational illness, or injury, or otherwise related to employment? <input type="checkbox"/> No <input type="checkbox"/> Yes – If yes give details separately. 4. If denture, crown, or bridge, is this the initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No If initial placement, advise date teeth were extracted _____ List all other missing teeth in arch _____ If replacement, give date of prior placement and reason for replacement. _____ 5. Is any treatment required for orthodontic purposes? <input type="checkbox"/> Yes <input type="checkbox"/> No Is any treatment from TMJ purposes? <input type="checkbox"/> Yes <input type="checkbox"/> No
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STUDENT INFORMATION

Group Number	Plan Name StudyWell Benefits	Carrier TELUS AdjudiCare	Carrier ID 000034
Name (Last, First)		Cert. No. or ID No.	Date of Birth
Address	Province	Postal Code	Phone number

STUDENT AUTHORIZATION

I hereby authorize any healthcare provider, my plan administrator, my Student Organization, insurance companies, other organizations, or benefit service providers working with StudyWell Benefits™ operated by Ellement Consulting Group to exchange information when necessary for the purpose of settlement of this claim and to administer the group plan. I authorize release of the information contained in this claim form to the Insurer/Plan Administrator, its authorized representative or consultant for the purpose of settlement of this claim. I understand the information collected is kept in strict confidence and used solely for the purpose of assessing the 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 and that each of the above expenses are for medical treatment that I and/ or my dependents received. 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 the provider for the entire amount. I agree that a photocopy or electronic copy of this form is as valid as the original.

_____ Student Signature	_____ Month Day Year Date Signed
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