Dental Care Claim Form ☐ Duplicate Form ☐ Predetermination

DENTAL SERVICE PROVIDER

PATIENT				PROVIDER				
Name (Last, First)				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.
Address				Name/Address			_____ Signature of Member
City	Province	Postal Code		Telephone Number			

For Dentist Use Only – For additional information, diagnosis, procedure, or special consideration.

Was this emergency treatment? ☐ No ☐ 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:

If charges exceed $500.00, 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	

PATIENT INFORMATION

Complete this section before taking the form to your dentist's office

1. Patient: Relationship to Member: Date of Birth: _____
   If Child, please indicate ☐ Full-Time Student ☐ 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? ☐ No ☐ Yes
   If this claim is for a child, please indicate spouse's date of birth: _____
3. Is the treatment result of an accident, occupational illness, or injury, or otherwise related to employment?
   ☐ No ☐ Yes – If yes give details separately.
4. If denture, crown, or bridge, is this the initial placement? ☐ Yes ☐ 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? ☐ Yes ☐ No
   Is any treatment from TMJ purposes? ☐ Yes ☐ No

MEMBER INFORMATION

Group Number	Plan Name	Carrier	Carrier ID
	Teamsters Local Union 230	**Telus AdjudiCare**	**000034**

Name (Last, First)		Cert. No. or ID No.	Date of Birth
Address	Province	Postal Code	Phone number

I hereby authorize any healthcare provider, my plan administrator, my employer, insurance companies, other organizations, or benefit service providers working with 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.

_____ Month Day Year _____

Member Signature ***(must be in ink)*** **Date Signed**

Plan Administrator
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