studywell™ Dental Care Claim Form

☐ Duplicate Form ☐ Predetermination

StudyWell Benefits

DENTAL SERVICE PROVIDER

PATIENT

Name (Last, First)		
Address		
City	Province	Postal Code

PROVIDER

Unique No.	Specialty	Patient's Office Acc't No.
Name/Address		
Telephone Number		

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

_____
Signature of Student

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 $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		

PATIENT INFORMATION

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

1. Patient: Relationship to Student: _____ 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 Yes, attach co-insurance statement.
   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

STUDENT INFORMATION

Group Number	Plan Name	Carrier	Carrier ID
	StudyWell Benefits	**TELUS AdjudiCare**	**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 ***(must be in ink)***

Month Day Year
_____
Date Signed

Plan Administrator
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Fax: 780.452.5388
Email: info@studywellbenefits.ca