



STANDARD DENTAL CLAIM FORM

ASSOCIATION		CLAIM FORM							
PART 1 DENTIST	UNIQUE NO. 070533851	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAY- MENT DIRECTLY TO HIM/HER							
P A T I E N T	D Dr. Tim D. Dumore E Dr. Tim Dumore & Team N 2541 Potage Avenue I Winnipeg, MB R3J 0P1 S T				14) 832-3910 SIGNATURE OF SUBSCRIBER				
FOR DENTIST'S USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION.			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 RELASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY / PLAN ADMINISTRATOR. I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED TO THE COVERAGE OF SERVICES DESCRIBED IN THIS FORM TO THE NAMED DENTIST.						
			SIGNATURE OF PATIENT (PARENT/GUARDIAN)						
DUPLICATE FORM DDO INTI TOOTH			OFFICE VERIFICATION	1 Jamos					
DATE OF SERVICE PRO- INTL. TOOTH DEN DAY MO. YR. CEDURE TOOTH SUR-	TORY GE	TOTAL CHARGES							
CODE CODE FACES				FOR CARRIER USE					
				ALLOWED AMOU	NT INC	%	PATIENT'S SI	HARE	
				CHEQUE NO.		DATE			
				DEDUCTIBLE	PATIENT PAY	S	PLAN PAYS		
THIS IS AN ACCURATE STATEMENT OF SERVICES PER- FORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE.	L FEE SUBMITT	ΓED		CLAIM NO.			·		
INSTRUCTIONS FOR CLAIM SUBMISSION									
BEING A STANDARD FORM, THIS FORM CANNOT INCLUDE SPECIFIC INSTRUCTIONS ON WHERE IT SHOULD BE SENT, DEPENDING ON WHO IS THE CARRIER FOR YOUR PLAN. YOU CAN OBTAIN DETAILS FROM EITHER YOUR PLAN BOOKLET, YOUR CERTIFICATE OR FROM YOUR EMPLOYER. IF YOUR PLAN REQUIRES SUBMISSION DIRECTLY TO THE CARRIER, PLEASE SEND THIS FORM WITH ONLY PARTS 1, 2 AND 3 COMPLETED TO THE CARRIER'S APPROPRIATE CLAIMS OFFICE. IF YOUR PLAN REQUIRES SUBMISSION TO YOUR EMPLOYER, PLEASE DIRECT THIS FORM TO YOUR PERSONNEL OFFICE/PLAN ADMINISTRATOR WHO WILL COMPLETE PART 4 AND FORWARD THE FORM TO THE CARRIER.									
PART 2 - EMPLOYEE/PLAN MEMBER/SUBSCRIBER									
GROUP POLICY/PLAN NO DIVISION/SEC		2. YOUR NAME (PLEASE PRINT)							
EMPLOYER			YOUR CERT. NO. OR S.I.N. OR ID. NO. YOUR DATE OF RIPTH						
	YOUR DATE OF BIRTHDAY MONTH YEAR								
NAME OF INSURING AGENCY OR PLAN									
PART 3 - PATIENT INFORMATION									
1. PATIENT: RELATIONSHIP TO EMPLOYEE/ PLAN MEMBER/SUBSCRIBER DATE OF BIRTH DAY MONTH YEAR			3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? IF YES, GIVE DATE AND DETAILS SEPARATELY.						
IF CHILD INDICATE IF STUDENT, INDICATE SCHOOL IF STUDENT, INDICATE SCHOOL			4. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT.						
PATIENT ID. NO.			5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? NO YES						
2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN, W.C.B. OR GOV'T PLAN? NO YES			6. I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO THE INSURER/PLAN ADMINISTRATOR AND CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.						
POLICY NO SPOUSE DATE OF BIRTH NAME OF OTHER INSURING AGENCY OR PLAN		SIGNATURE OF EMPLOYEE/PLAN MEMBER/SUBSCRIBER DAY MONTH YEAR							
PART 4 - POLICY HOLDER/EMPLOYER (FOR COMPLETION ONLY IF APPLICABLE, SEE ABOVE*)									
1. DATE COVERAGE COMMENCED DAY MONTH YEAR 4.		DATE AUTHORIZED SIGNATURE							
2. DATE DEPENDENT COVERED		DA	Y MONTH YEAR						
3. DATE TERMINATED	ALL INFORMATION RECORDE				(POSITIO	N OR TITLE)		_ _	