claimsecure

HealthSource Plus®

HealthSource Plus is a People Corporation company

DENTAL CLAIM FORM

PART 1 – DENTIST

UNIQUE NO. ❑ SPEC. ❑ PATIENT'S OFFICE ACCOUNT NO.

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER

PATIENT

PHONE NO.

DENTIST

PHONE NO.

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 RELEASE 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 AND THE PLAN MEMBER.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

DUPLICATE FORM ❑

OFFICE VERIFICATION/DENTIST'S SIGNATURE

DATE OF SERVICE			PROCEDURE CODE	INT'L TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES	FOR CARRIER USE			
DAY	MO.	YR.							ALLOWED AMOUNT	INC.	%	PATIENT'S SHARE
								$0.00				
								$0.00				
								$0.00				
								$0.00				
								$0.00				
								$0.00	CHEQUE NO.		DATE	
								$0.00	DEDUCTIBLE	PATIENT PAYS		PLAN PAYS
THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & O.E.					TOTAL FEE SUBMITTED			$0.00	CLAIM NO.			

PART 2 – EMPLOYEE / PLAN MEMBER / SUBSCRIBER

1. GROUP POLICY / PLAN NO. _____ DIVISION / SECTION NO. _____

EMPLOYER _____

NAME OF INSURING AGENCY OR PLAN ClaimSecure Inc.

2. YOUR NAME (PLEASE PRINT) _____

YOUR CERTIFICATE NO.
OR S.I.N. OR I.D. NO. _____

YOUR DATE OF BIRTH _____
DAY MONTH YEAR

PART 3 – PATIENT INFORMATION

1. PATIENT: RELATIONSHIP TO EMPLOYEE/ PLAN MEMBER / SUBSCRIBER _____

DATE OF BIRTH _____
DAY MONTH YEAR

IF CHILD, INDICATE STUDENT ❑ HANDICAPPED ❑

IF STUDENT, INDICATE SCHOOL _____

PATIENT I.D. NO. _____

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

POLICY NO. _____ SPOUSE DATE OF BIRTH _____

NAME OF OTHER INSURING AGENCY OR PLAN _____

3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? IF YES, GIVE DATE AND DETAILS ❑ NO ❑ YES

4. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT ❑ NO ❑ YES

5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? ❑ 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

DATE _____
DAY MONTH YEAR

SIGNATURE OF EMPLOYEE / PLAN MEMBER / SUBSCRIBER

PART 4 – POLICY HOLDER / EMPLOYER (FOR COMPLETION ONLY IF APPLICABLE, SEE ABOVE*)

	DAY	MONTH	YEAR	CONTRACT HOLDER	DAY	MONTH	YEAR
1. DATE COVERAGE COMMENCED							
2. DATE DEPENDENT COVERED							
3. DATE TERMINATED							

AUTHORIZED SIGNATURE

(POSITION OR TITLE)

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL. UNLESS ASSIGNED, BENEFITS ARE PAYABLE TO THE PLAN MEMBER.

*** NOTE: DO NOT STAPLE OR TAPE RECEIPTS TO THE CLAIM FORM ***

CLAIMSECURE INC.

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