MACNAUGHTON & WARD
FINANCIAL SERVICES LTD.

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		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	LAB CHARGE	TOTAL CHARGES	FOR CARRIER USE			
DAY	MONTH	YEAR							ALLOWED AMOUNT	INC.	%	PATIENT'S SHARE
									CHEQUE NO.		DATE	
									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				CLAIM NO.			

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PART 2: EMPLOYEE / PLAN MEMBER / SUBSCRIBER

1. GROUP POLICY / PLAN NO.	DIVISION / SECTION NO.	2. YOUR NAME (PLEASE PRINT)
EMPLOYER		YOUR CERTIFICATE NO. / SIN / ID NO.
NAME OF INSURING AGENCY OR PLAN		YOUR DATE OF BIRTH (DAY/MONTH/YEAR)

PART 3: PATIENT INFORMATION

1. PATIENT RELATIONSHIP TO EMPLOYEE / PLAN MEMBER / SUBSCRIBER	3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? IF YES, GIVE DATE AND DETAILS ☐YES ☐NO
DATE OF BIRTH (DAY/MONTH/YEAR)	
IF CHILD, INDICATE ☐STUDENT ☐HANDICAPPED	4. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? IF YES, GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT ☐YES ☐NO
IF STUDENT, INDICATE SCHOOL	
PATIENT ID NO.	5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? ☐YES ☐NO
2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN, W.C.B. OR GOV'T PLAN? ☐YES ☐NO POLICY NO. _____ SPOUSE DATE OF BIRTH _____ NAME OF OTHER INSURING AGENCY OR PLAN _____	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	AUTHORIZED SIGNATURE
1. DATE COVERAGE COMMENCED								
2. DATE DEPENDENT COVERED								POSITION / TITLE
3. DATE TERMINATED								