



# DENTAL CLAIM

Please print your Firm & Certificate #

Firm # _____	Certificate # _____
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Unique # _____	Spec. _____	Patient's Office Account # _____	P Patient's Name _____ A Home Address _____ T City _____ I Province _____ Postal Code _____ N T
D E N T I S T  Phone Number _____			

DATE OF SERVICE			PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES
DAY	MO.	YR.						
<b>TOTAL FEE SUBMITTED</b>								

FOR DENTIST'S USE, FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION

**OPTIONAL ASSIGNMENT OF BENEFITS**  
 I hereby assign my benefits payable from this claim and authorize payment directly to the named Dentist.

**Employee's Signature** \_\_\_\_\_

- Name of Employer** \_\_\_\_\_
- Name and address of Employee \_\_\_\_\_  
 \_\_\_\_\_ Employee's birthdate (YYYY/MM/DD) \_\_\_\_\_
- Patient's relationship to Employee \_\_\_\_\_ Patient's birthdate (YYYY/MM/DD) \_\_\_\_\_
- Are you or your dependents entitled to benefits under any other plan?  No  Yes If "Yes," family member insured \_\_\_\_\_  
 Name of insuring company \_\_\_\_\_ Spouse's birthdate (YYYY/MM/DD) \_\_\_\_\_
- Are any of the services provided as a result of an accident?  No  Yes  
 If "Yes," provide the date and details of the accident. \_\_\_\_\_
- Are you claiming for a dependent child who is age 21 or older?  No  Yes  
 Child is  physically/mentally handicapped (medical evidence may be requested)  
 a student enrolled **full time** at (school's name) \_\_\_\_\_
- If treatment is a denture, crown or bridge, is it an initial placement?  No  Yes  
 If "No," provide the last placement date and reason for replacement. \_\_\_\_\_
- Is any treatment required for orthodontic purposes?  No  Yes

All the information I have provided on the form is accurate and complete, to the best of my knowledge, and represents a claim for services rendered to me and/or eligible members of my family. If this claim is being made on behalf of my spouse and/or dependents, I am authorized to disclose information about them for the purposes of assessing and paying a benefit, if any.

I authorize Chambers of Commerce Group Insurance Plan to collect, use, maintain and disclose personal information relevant to this claim for the purposes of benefit plan administration, assessment, investigation, claim management, underwriting and for determining Plan eligibility. The non-exhaustive list of sources from which information can be collected includes medical and health professionals, facilities or providers, insurance companies, or other organizations/persons. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the administration of benefits under this plan. A photocopy of this authorization is as valid as the original.

**Signature of Employee** \_\_\_\_\_ Date \_\_\_\_\_

## DENTAL CLAIM

### INSTRUCTIONS (Please read carefully)

The Dentist completes shaded areas. The Employee completes all other sections.  
Please ensure all questions are answered or your claim may take longer to process.

Send completed claim form to:

**Chambers of Commerce Group Insurance Plan**  
**582 King Edward Street**  
**Winnipeg, Manitoba R3H 0P1**



### WANT TO GET YOUR CLAIM PAID FASTER? SUBMIT YOUR CLAIMS ONLINE

- Go to [www.my-benefits.ca](http://www.my-benefits.ca) and register for the Plan member secure site
- Sign up for **DIRECT DEPOSIT**
- Submit claims online and **SAVE TIME, PAPER AND MONEY!**