NDT Benefits
Career — Health — Security

# NDT Industry Health Benefit Plan

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www.ndtbenefits.org

## STANDARD DENTAL CLAIM FORM

Canadian Dental Association

Canadian Life and Health Insurance Association Inc.

## PART 1 — DENTIST

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

PATIENT

LAST NAME GIVEN NAME

ADDRESS APT.

CITY PROV. POSTAL CODE

DENTIST

PHONE NO.

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

SIGNATURE OF SUBSCRIBER

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

DUPLICATE FORM ☐

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 THE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO THE PLAN ADMINISTRATION OFFICE, MY INSURER, AND MY POLICYHOLDER. THE INFORMATION RELEASED THROUGH THIS AUTHORIZATION IS TO BE USED FOR CLAIMS ADJUDICATION PURPOSES AND STATISTICAL ANALYSIS.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION/DENTIST'S SIGNATURE

| DATE OF SERVICE YR. | MO. | DAY | PROCEDURE CODE | INTL. TOOTH CODE | TOOTH SURFACES | DENTIST'S FEE | LABORATORY CHARGE | TOTAL CHARGES |
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THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE.

**TOTAL FEE SUBMITTED**

FOR CARRIER USE

CLAIM NUMBER

IF YOUR DENTIST RECOMMENDS A COURSE OF TREATMENT INVOLVING FEES OF $600.00 OR MORE, THEIR TREATMENT PLAN MAY BE SUBMITTED TO GREENSHIELD CANADA IN ADVANCE FOR PREDETERMINATION OF BENEFITS. GREENSHIELD CANADA WILL INFORM YOU, BEFORE YOU UNDERTAKE TREATMENT, OF THE AMOUNT ALLOWED BY THE PLAN.

## INSTRUCTIONS FOR CLAIM SUBMISSION

1. HAVE THE ATTENDING DENTIST COMPLETE PART 1.
2. COMPLETE PARTS 2 AND 3 BELOW ON EACH FORM SENT IN.
3. ALL PARTS OF THIS FORM MUST BE COMPLETED IN FULL. IF NEEDED INFORMATION IS MISSING, THE FORM MAY BE RETURNED TO YOU.
4. **ALL CORRESPONDENCE, CLAIM FORMS, ETC. . . . MAIL TO:** PLAN ADMINISTRATION OFFICE

## PART 2 — MEMBER

1. CONTROL NO./PLAN NO. _____ BRANCH NO. _____

EMPLOYER _____

2. NAME OF MEMBER _____

ADDRESS OF MEMBER _____

MEMBER'S DATE OF BIRTH: YEAR _____ MONTH _____ DAY _____

MEMBER'S CERTIFICATE/I.D. NUMBER _____

## PART 3 — PATIENT INFORMATION

1. PATIENT: RELATIONSHIP TO MEMBER _____

DATE OF BIRTH: YEAR _____ MONTH _____ DAY _____

2. IF CLAIM IS FOR DEPENDENT CHILD, IS THAT CHILD

HANDICAPPED? ☐ YES NO ☐ MARRIED? ☐ YES NO ☐

A FULL TIME STUDENT? ☐ YES NO ☐ EMPLOYED? ☐ YES NO ☐

3. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER PLAN OF INSURANCE OR DENTAL SERVICES: ☐ YES NO ☐ IF "YES," PROVIDE:

POLICY NUMBER: _____

NAME OF INSURER: _____

SPOUSE'S NAME: _____

SPOUSE'S DATE OF BIRTH: YEAR _____ MONTH _____ DAY _____

4. IS ANY OF THE ABOVE WORK FOR ORTHODONTIC PURPOSES? ☐ YES NO ☐

5. A) IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? ☐ YES NO ☐

GIVE DATE AND DETAILS _____

B) IS CLAIM BEING MADE FOR WORKERS' COMPENSATION BENEFITS? ☐ YES NO ☐

6. IF THE TREATMENT INVOLVES THE PLACEMENT OF A BRIDGE, DENTURE OR CROWN:
A) IS THIS THE INITIAL PLACEMENT?

UPPER ☐ YES NO ☐ LOWER ☐ YES NO ☐

B) IF "NO" GIVE THE DATE OF PRIOR PLACEMENT AND THE REASON FOR REPLACEMENT

_____

C) DATE OF EXTRACTIONS _____

Privacy Statement: The Plans will collect, maintain and communicate only the Personal Information considered necessary for the administration of the Plans. Personal Information will be protected pursuant to the applicable legislation. The Plans may use and exchange information with relevant persons and organizations including the Trustees, institutions, investigative agencies, unions, insurers, re-insurers, auditors, legal counsel, actuaries, payroll/payment providers, Plan administrators, and regulatory authorities in order to manage the Plans and entitlement to the benefits of the Plans. Questions related to the Privacy Policy should be directed to the Benefit Administration Office.

MEMBER'S SIGNATURE: _____

DATE: YEAR _____ MONTH _____ DAY _____

**ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL**