

PART 1: DENTIST			UNIQUE #	SPEC	PATIENT ACCOUNT	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM /HER		
PATIENT			DENTIST					
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 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			
DUPLICATE FORM _____					SIGNATURE OF PATIENT (PARENT/GUARDIAN)			

DATE			PROCEDURE CODE	INTERNAL TOOTH CODE	TOOTH SURFACE	LAB CHARGES	TOTAL CHARGES	FOR CARRIER USE			
DAY	MO	YR						ALLOWED AMOUNT	INC	%	PATIENT 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 & OE.	TOTAL FEE SUBMITTED:	CLAIM NO.
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INSTRUCTIONS FOR CLAIMS 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 PART 1, 2 & 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

1 GROUP POLICY / PLAN NO.	2 NAME
EMPLOYER	CERT/SIN/ID NO.
NAME OF INSURING AGENCY OR PLAN : DCM CONSULTING LTD.	DATE OF BIRTH (D/M/YR)

PART 3 – PATIENT INFORMATION

1 PATIENT: RELATIONSHIP TO EMPLOYEE / PLAN MEMBER / SUBSCRIBER DATE OF BIRTH (D/M/YR) IF CHILD INDICATE: STUDENT _____ HANDICAPPED _____ IF STUDENT, INDICATE SCHOOL: PATIENT ID NO.	3 IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? IF YES, GIVE DATE AND DETAIL SEPERATELY 4 IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? GIVE DATE OR PRIOR PLACEMENT AND REASON FOR REPLACEMENT. GIVE DATE & DETAILS SEPERATELY 5 IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES?	<table border="1" style="width: 100%;"> <tr><td>NO</td><td>YES</td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>	NO	YES						
NO	YES									

2 ARE ANY 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 INSURANCE AGENCY OR PLAN _____

I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO THE INSURE / PLAN ADMINISTRATOR AND CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE
 DATE: (D/M/YR) _____

SIGNATURE OF EMPLOYEE / PLAN MEMBER / SUBSCRIBER

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

1 DATE OF COVERAGE COMMENCED 2 DATE DEPENDANT COVERED 3 DATE TERMINATED	<table border="1" style="width: 100%;"> <tr><th>DAY</th><th>MONTH</th><th>YEAR</th></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </table>	DAY	MONTH	YEAR										4 CONTRACT HOLDER <table border="1" style="width: 100%;"> <tr><th>DAY</th><th>MONTH</th><th>YEAR</th></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </table>	DAY	MONTH	YEAR									
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AUTHORIZED SIGNATURE (POSITION OR TITLE)