

PO Box 1608, Windsor, Ontario N9A 7G1 Attn: Dental Department or CUSTOMER SERVICE CENTRE 1-888-711-1119

DENTAL CLAIM FORM

												DENTAL CLAIM FORM													
PA.	RT :	1 - Pl	ROVI	DEI	?					Unique No Spec Patient's Office Account No.								I hereby assign my benefits payable from this claim to the named provider and authorize							
Patient Last Name Given Name P R A T Address Apt. V I																	payment directly to him/her.								
E D E																									
T City Province Postal Code R											Phone No										Signature of Plan Member				
For provider's use only - for additional information, diagnosis,										T un				fees li	eted i	n this	claim	may	not be					eed my plan bene	ofite I
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	tate of Service Y MO YR Procedure Code Int'l Tooth Code Surfaces									Provider's Fee Laboratory Charge							Т	Fotal (Charge	es	Allowed Amount	Code			
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INS Plea	INSTRUCTIONS FOR CLAIM SUBMISSION Please carefully fill in all pertinent areas and sign the completed claim form. (Refer to Green Shield Identification Card for correct patient information). Incomplete or incorrect claim forms will be returned or rejected and will result in a delay in reimbursement.														ation).										
PA	RT :	2 - E	MPL	OYE	E/PI	LAN I	МЕМ	BER				All claims must be submitted within 12 (unless otherwise stated in your benefit plan													ce
Plan	Men	nber's	Nam	e (Pl	ease	Print	t)				_[Plan Member's Identification Number										_[nber's Date of Birth	
La	st Nam						Giv	ven Names			- [- 0 0											Yr	Mo Day	
PART 3 - PATIENT INFORMATION																									
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	st Name		10 (2	auc	144,		Given	Names			Patient's Identification Number -														
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	re any o		benefit	ts or se	services			inder any other	group insura	nce or	4. If denture, crown or bridge, is this initial placement? Give date of prior placement and reason for replacement. 5. Is any treatment required for orthodontic purposes? No Yes														
If	f Yes, P		No				-	pouse Date of B	_	ins	ısurer/p		dminis	strator					rmatio	-		respect of this ene, correct and cor			
					-			fidential.	_	Signature of Plan Member									Day Month Year						
																								by me to Green Shie	

I am authorized by my spouse and/or dependants to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder.