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

PHONE NO.:

DENTIST

NAME:

ADDRESS:

EMAIL:

PHONE NO.:

SIGNATURE OF SUBSCRIBER

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

DUPLICATE FORM ☐

I certify that the above information is true and complete and that the above charges were for goods and services received by me, my spouse or my eligible dependents. I certify that I am authorized to disclose and receive information about my spouse and/or dependents for purposes of assessing and paying a benefit if any. If I am submitting personal information about myself and/or my spouse and/or dependents, I acknowledge that I/he/she/we/they have reviewed and consent to the Disclaimer and Privacy Policy (https://www.claimsecure.com/privacy/). I acknowledge that unless assigned to the service provider, any reimbursement of the above charges and explanation of such amounts paid will be provided to the benefit plan member. I authorize ClaimSecure, healthcare professionals, insurers, administrators of government or other benefit plans, and other service providers working with ClaimSecure to exchange necessary information regarding this claim to administer my health benefit plan. I understand and agree that ClaimSecure will conduct audits of claims submitted by me for purposes including, but not limited to, preventing and detecting fraud. I authorize ClaimSecure, and persons acting for ClaimSecure, to disclose this claim, or any personal information contained in this claim, to the benefit plan sponsor/employer for the purposes of reporting fraud suspicious claims. I am aware that under certain circumstances permitted by law, ClaimSecure, or persons acting on its behalf, may be required or permitted to disclose this claim, and the information contained in this claim, including personal information, to others without my knowledge or consent, or the consent of the individual to whom the information relates. In all other circumstances, ClaimSecure will only disclose such personal information in accordance with ClaimSecure's Privacy Policy (https://www.claimsecure.com/privacy/). We may revise this Disclaimer from time to time, and will post the most current version on our website at (https://www.claimsecure.com). Please check back from time to time to ensure that you are aware of any changes and are using the most recent version of the Disclaimer. Your continued use of our services after any such changes constitutes your acceptance of the Disclaimer as revised.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION/DENTIST'S SIGNATURE

DATE OF SERVICE DAY	MO.	YR	PROCEDURE CODE	INT'L TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES
								$ 0.00
								$ 0.00
								$ 0.00
								$ 0.00
								$ 0.00
								$ 0.00
								$ 0.00

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & O.E.

TOTAL FEE SUBMITTED $ 0.00

FOR CARRIER USE

ALLOWED AMOUNT	INC.	%	PATIENT'S SHARE

CHEQUE NO. DATE

DEDUCTIBLE	PATIENT PAYS	PLAN PAYS

CLAIM NO.

PART 2 – EMPLOYEE / PLAN MEMBER / SUBSCRIBER

1. GROUP POLICY / PLAN NO. _____ DIVISION / SECTION NO._____

EMPLOYER _____

NAME OF INSURING AGENCY OR PLAN ClaimSecure Inc.

2. YOUR NAME (PLEASE PRINT) _____
YOUR CERTIFICATE NO.
OR I.D. NO. _____

YOUR DATE OF BIRTH _____
DAY MONTH YEAR

YOUR EMAIL ADDRESS _____

3. DO YOU WANT ANY UNPAID BALANCE FROM THIS CLAIM REIMBURSED FROM YOUR HEALTH SERVICE SPENDING ACCOUNT (IF ELIGIBLE)? YES ☐ NO ☐

PART 3 – PATIENT INFORMATION

1. PATIENT:

RELATIONSHIP TO EMPLOYEE/ PLAN MEMBER / SUBSCRIBER _____

DATE OF BIRTH _____
DAY MONTH YEAR

IF CHILD, INDICATE STUDENT ☐ HANDICAPPED ☐

IF STUDENT, INDICATE SCHOOL _____

PATIENT I.D. NO. _____

2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHE GROUP INSURANCE OR DENTAL PLAN, W/.C.B. OR GOV'T PLAN? NO ☐ YES ☐

POLICY NO. _____ SPOUSE DATE OF BIRTH _____

NAME OF OTHER INSURING AGENCY OR PLAN _____

3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? IF YES, GIVE DATE AND DETAILS NO ☐ YES ☐

4. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT NO ☐ YES ☐

5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? NO ☐ YES ☐

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
1. DATE COVERAGE COMMENCED							
2. DATE DEPENDENT COVERED							
3. DATE TERMINATED							

AUTHORIZED SIGNATURE

(POSITION OR TITLE)

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL. UNLESS ASSIGNED, BENEFITS ARE PAYABLE TO THE PLAN MEMBER.

*** NOTE: DO NOT STAPLE OR TAPE RECEIPTS TO THE CLAIM FORM ***

CLAIMSECURE INC.

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