Green Shield CANADA

Where quality is more than a claim

P. O. BOX 1608
Windsor, Ontario N9A 7G1
Attn: Dental Department
or Customer Service Centre 1-888-711-1119

DENTAL CLAIM FORM

PART 1 - PROVIDER

PATIENT

Partient Last Name | Given Name

Address | Apt.

City | Prov. | Postal Code

PROVIDER

Unique No. | Spec | Patient's Office Account No.

Phone No.

I hereby assign my benefits payable from this claim to the named provider and authorized payment directly to him/her

Signature of Subscriber

For provider's use only - for additional information, diagnosis, procedures, or special consideration.

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 provider 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.

Signature of Patient (Parent/Guardian)

Office Verification

Duplicate Form

Date of Service DAY MO YR.	Procedure Code	Int'l Tooth Code	Tooth Surfaces	Provider's Fee	Laboratory Charges	Total Charges	Allowed Amount	Code

INSTRUCTIONS FOR CLAIM SUBMISSION: Please carefully fill in all pertinent areas and sign the completed 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 reimbursment.

PART 2 - EMPLOYEE/PLAN MEMBER/SUBSCRIBER

Subscriber's Name (Please print) | Subscriber's Identification Number -- 00 | Subscriber's Date of Birth Yr Mo Day

Last Name | Given Names

PART 3 - PATIENT INFORMATION

Patient's Name (Please print) | Patient's Identification Number -- | Patient's Date of Birth Yr Mo Day

Last Name | Given Names

1. Patient: Relationship to Subscriber

If child, indicate: Student ☐ Handicapped ☐

if student, indicate school

2. Are any dental benefits or services provided under any other group insurance or dental plan, W.S.I.B. or Government plan? No ☐ Yes ☐

If 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 separately. 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 ☐

Signature of Subscriber | Date Yr Mo Day

All claims must be submitted within 12 months of the date of service.

By signing this claim form and/or submitting actual receipts, I agree that the information provided is complete and accurate, to the best of my knowledge. I authorize Green Shield Canada to exchange information with other parties as required and only when the information is needed to administer this benefit claim and/or to confirm the accuracy of this information.