MANION

GROUP DENTAL CLAIM FORM

PART 1 - DENTIST

UNIQUE NO. SPEC.

PATIENT'S OFFICE ACCOUNT N

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

PATIENT

LAST NAME GIVEN NAME

ADDRESS APT.

CITY PROV. POSTAL CODE

DENTIST

PHONE NO.

SIGNATURE OF SUBSCRIBER

FOR DENTISTS USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES OR SPECIAL CONSIDERATION.

I understand the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand I am financially responsible to my dentist for the entire treatment. I acknowledge that the total fees 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 for the purpose of processing my claim.

Signature of Patient (Parent / Guardian)

OFFICE VERIFICATION

DUPLICATE FORM ☐

DATE OF SERVICE Day	Mo.	Year	PROCEDURE CODE	INT. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

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

TOTAL FEE SUBMITTED:

PLEASE SUBMIT COMPLETED CLAIM FORM TO:

Manion, Wilkins & Associates Ltd.
626 - 21 Four Seasons Place
Etobicoke, Ontario
M9B 0A6

Phone: (416) 234-5044
Toll Free: 1-800-263-5621

PART 2 - EMPLOYEE INFORMATION

Plan No: **CERTIFICATE #**

1. Employee's name ______________________ Date of Birth ___ / ___ / ___ (Day Mth Year)

2. Employee's Address ______________________ (Street, City/Town) ______________ (Phone Number)

   Is this an address change? Yes ☐ No ☐

3. Do you or your dependent(s) have any other Insurance to cover these benefits? ☐ Yes ☐ No

   If yes, please specify ______________ (Insurance Company Name) ______________ (Policy Number) ______________ (Certificate Number)

4. If denture, bridge or crown, is this an initial placement? ☐ Yes ☐ No
   If initial placement, advise the date teeth were extracted and all other missing teeth. ______________
   If replacement, advise date of prior placement and reason for replacement. ______________

If this claim is for a spouse or child, complete the following information:

5. Dependent's Date of Birth ___ / ___ / ___ (Day Month Year)

6. Relationship to Member ☐ Spouse ☐ Child

7. Is this dependent working? ☐ Yes ☐ No   Is this dependent attending school? ☐ Yes ☐ No

   If YES give name of employer or school ______________

8. If treatment is due to an accident, indicate date of accident and details. ______________

I hereby certify that the above statements are true, accurate and complete to the best of my knowledge and belief. I understand that the Plan Administrator will use the information provided by me on this claim form strictly to process my claim. I hereby authorize the Plan Administrator to evaluate or investigate my claim, and release my personal information (including health information) to qualified third parties solely for the purpose of conducting such evaluations or investigations, and only to the extent required for such purposes.
I hereby authorize my employer, any licensed dentists or other health professionals, any medical facility, any insurance company or government body, and any other person or institution to release relevant information to the Plan Administrator solely for the purpose of processing this claim. A photocopy of this release shall be as valid as the original.

Signature of Employee ______________________ Date ______________