

STANDARD DENTAL CLAIM FORM



PART 1 DENTIST										UNIQ	UNIQUE NO.			SPEC. PATIE			NTS ACCOUNT NO.	I HEREBY ASSIGN MY BENEFITS PAYABLE	
P LAST NAME GIVEN NAME A											D E							FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT TO	
T ADDRESS										N HIM/HER.									
E										I									
T PROVINCE POSTAL CODE										T PHONE NO.							SIGNATURE OF SUBSCRIBER		
FOR DENTIST'S USE ONLY, FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES OR SPECIAL CONSIDERATION.										UND THE I AU ADM DES	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 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. SIGNATURE OF PATIENT (PARENT/GUARDIAN)								
DUPLICATE FORM \square										OFF	ICE VE	ERIFICATI	ON						
Date of Se	_	Proced		Tooth Code	Tooth Surfaces	Dentists Fee				Lab Charge				TOTA	L CHAR	GES		INSTRUCTIONS	
						П		\Box					П				All claims under this group benefits plan are submitted		
	┷		$+\!\!\!+\!\!\!\!+$	₩	<u> </u>	Н	+	$oldsymbol{\sqcup}$		Н	$\vdash \vdash$	╀	igapha				_	plan member. We may exchange personal about claims with the plan member and a	
	\vdash	++	++	╁┼	├──	₩	+	╁		$oldsymbol{H}$	\vdash	+-	╁┼	+	\vdash	+-		on his or her behalf when necessary to confirm	
		Ħ	tt	${\dagger}{\dagger}$		H	+	$\forall t$		H	H	+	ff	+	H	1		to mutually manage the claims.	
						П		П									-	dentist complete Part 1 er completes Parts 2 and 3	
			Ш			Ш	L	Ш			Ш		Ш					benefits to be paid directly to the dentist, sign	
	Ш	Н-	$+\!\!\!+\!\!\!\!+$	₩		Н	+	\sqcup		Ш	\vdash	 	$oldsymbol{\sqcup}$				–	t portion of Part 1 above.	
	\vdash	++	╁┼	╁┼╴	├──	₩	+	₩		H	\vdash	+-	╁┼	+	\vdash	+	4. SEND THIS		
		Ħ	tt	${\dagger}{\dagger}$		H	+	$\forall t$		H	H	+	ff	+	H	1	N.	B Pipe Trades Admin Office	
						П	工	Ш					Ш] .	5 Blizzard Street	
					SERVICES D PAYABLE,		TAI	L FE	E SI	UBN	ит.	TED:					h	Fredericton, NB E3B 8K3 506-459-6040	
E, & O.E.																		300 107 0010	
PLAN NAN																		DATE OF BIRTH:/	
PLAN MEN	MBER AD	DRESS: _																	
	of our P	rivacy Gu																sessing your claim and administering the group benefits plan viders), write to NexgenRx's Chief Privacy Officer or refer to	
organizati	ons or se	rvice pro	viders w	vorking w	vith Nexgenl	Rx/NB	3 Pipe	Trades	s, locat	ted w	rithin o	or outside	Canad	a, to e	xchange	persor	nal information when	of government benefits or other benefits programs, other necessary for these purposes. I understand that persona rect and complete to the best of my knowledge.	
PLAN M	MEMBER'S	SIGNAT	URE:														I	DATE:	
PART	13 (:00R	DIN/	ATIO	N OF E	BEN	1313	TS											
1. Patient's						7-151												2. Patients Date Of Birth:/	
3. If the pa	atient is a	child, do	es the pa	tient resi	de with you	.? 🗆	Yes		No									DAY MONTH YEA	
4. If the ch	hild is ove	er over:	a) Is he/	she a full	-time studer	nt?] Yes	;	No										
			b) If stud	lent, how	many hours	s per w	veek at	c school	1?										
			c) Is he/	she empl	oyed?	Yes		No If	yes, ho	ow ma	any ho	urs worke	ed per v	week?					
5. Are you	ı or any o	ther men	iber of yo	our family	entitled to	benefi	ts und	er any	other	plan?		Yes \square	No						
If ye	es, name o	f family r	nember i	nsured:						_ Rela	ationsl	nip to plan	ı memb	er:					
Nam	ne of othe	r insuran	ce compa	any:					Po	olicy/(Group	Number:							
6. Is this	treatmei	ıt requir	ed as the	e result o	f an accide	nt? [□ Ye	s 🗆] No	If ye	s, plea	ise attacl	ı detail	ls of th	e accid	ent (ie	date, location, how	it happened)	
7. Is a clai	im being i	nade for	Worker's	Compen:	sation Benef	fits? [es 🗆	□ No										
8. If claim	is for de	nture, cro	wn or br	idge, is th	nis initial pla	cemen	ıt? 🗆] Yes		No	If no), give dat	e of pri	ior plac	ement a	and reas	son for replacement:		