GROUP DENTAL CLAIM FORM

PART 1 – DENTIST

UNIQUE NO. | 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

Last Name | Given Name

Address | Apt

City | Prov | Postal Code

DENTIST

PHONE NO.

Signature of Subscriber

FOR DENTIST'S 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.

Signature of Patient *(Parent/Guardian)*

DUPLICATE FORM ☐

OFFICE VERIFICATION / DENTIST'S SIGNATURE

Date of Service Day	Mo.	Yr	PROCEDURE CODE	INT. TOOTH CODE	TOOTH SURFACES	DENTIST FEE	LABORATORY CHARGE	TOTAL CHARGES

PLEASE SUBMIT CLAIM FORM TO:

myGroupHEALTH

Mail: 626-21 Four Seasons Place
Etobicoke, ON M9B 0A6
Email: claims@mygrouphealth.ca
Fax: 416-234-2071
Toll-Free: 1-833-344-6944

Plan Administrator Use Only

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

TOTAL FEE SUBMITTED:

PART 2 – MEMBER complete this section *(please print)*

Plan Name: | Group Number:

Member Name: | Certificate Number: | Date of Birth (Day Month Year)

Member Address | City / Town | Prov | Postal Code

1. 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

2. 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.
Date:

If replacement, advise date of prior placement and reason for replacement.
Date:

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

Dependent's Date of Birth (Day Month Year)	Relationship to Member	Is this dependent working?	Is this dependent attending school?	If yes, give name of employer or school
	☐ Spouse ☐ Child	☐ Yes ☐ No	☐ Yes ☐ No	

4. 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 for the purpose of processing my claim. I hereby authorize the use of my Social Insurance Number for tax reporting and the administration of my benefits. I hereby authorize the Plan Administrator to evaluate or investigate my claims 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, physician or other health professionals, any medical or dental facility, any insurance company or government body, and any other person or institutions 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.

Member's Signature | Date | Phone Number