STANDARD DENTAL CLAIM FORM

PART 1 DENTIST	UNIQUE NO	SPEC.	PATIENTS OFFICE ACCOUNT NUMBER	I HEREBY ASSIGN MY BENEIFTS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTORHIZE PAYMENT TO HIM/HER
PATIENT FIRST NAME LAST NAME ADDRESS APT # CITY PROVINCE POSTAL CODE	DENTIST PHONE NUMBER _____			SIGNATURE OF SUBSCRIBER

FOR DENTIST USE ONLY. ANY ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURE OR SPECIAL CONSIDERATIONS	I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM FORM MAY NOT BE COVERED OR MAY EXCEED MY PALN BENEFIT. 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 CHARDGE TO ME FOR SERVICES RENDERED. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY/PLAN ADMINISTRATOR. I ALSO AUTHROIZE THE COMMUNICATION OF INFORMATION RELATED TO THE COVERAGE OF SERVICES DESCRIBED IN THIE FORM TO THE NAMED DNETIST. SIGNATURE OF PATIENT(PARENT/GUARDIAN) _____

DATE OF SERVICE DAY	MON	YR	PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTISTS FEES	LABORATORY CHARGES	TOTAL CHARGES

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

TOTAL FEE SUBMITTED

FOR CARRIER USE

ALLOWED AMOUNT	INC	%	PATIENT'S SHARE

CHQ. NO.		DATE	
DEDUCTIBLE	PATIENT PAYS	PLAN PAYS	

CLAIM NO.

INSTURCTIONS FOR CLAIM SUBMISSION

PLEASE CAREFULLY FILL IN ALL PERTINENT AREAS AND SIGN THE COMPLETED CLAIM FORM. INCOMPLETE CLAIM FORMS WILL BE RETURNED OR REJECTED AND WILL RESULT IN A DELAY IN REIMBURSEMENT.

PART 2 – EMPLOYEE/PLAN MEMBER/SUBSCRIBER

SUBSCRIBERS NAME LAST NAME FIRST NAME SUBSCRIBERS CERTIFICATE NUMBER _____ SUBSCRIBERS DATE OF BIRTH _____ DAY MONTH YEAR	NexgenRx GROUP POLICY/PLAN NUMBER _____ DIVISION NUMBER _____ EMPLOYER _____ IF YOU HAVE A HEALTH CARE SPENDING ACCOUNT DO YOU WANT ANY UNPAID ELIGIBLE BALANCES PROCESSED FROM THAT ACCOUNT? YES NO

PART 3 – PATIENT INFORMATION

1. PATIENT NAME _____

   RELATIONSHIP TO INSURED _____

   DATE OF BIRTH _____ IF CHILD INDICATE : STUDENT HANDICAPPED
   DAY MONTH YEAR

   IF STUDENT CHILD INDICATE SCHOOL _____
   PATIENT ID _____

2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE PLAN? ___YES ___NO

   IF YES, POLICY NUMBER _____ SPOUSE'S DATE OF BIRTH _____

   NAME OF OTHER INSURING AGENCY _____

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

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

5. IS ANY TREATMENT REQUIRED FOR OTHODONTIC TREATMENT? NO YES

I authorize the release of any information on records required in respect of this claim to insurer's plan administrator and certify that information given is true, correct and complete to the best of my knowledge.

Signature of subscriber Date day month year

ALL INFORMATION RECORDED ON THIS FORM IS PRIVATE AND CONFIDENTIAL. Your claim and your coverage may be denied or terminated if you provide false, incomplete, or misleading information, and we may share information with your plan sponsor without further notification to you. Any monies or overpayments that you may owe in accordance with the provisions of the Group Benefits plan must be repaid. NexgenRx may deduct such monies from your future claim payments or purse such other lawful remedies as we deem necessary.