STANDARD DENTAL CLAIM FORM

PART 1 DENTIST

PATIENT	UNIQUE NO	SPEC.	PATIENTS OFFICE ACCOUNT NUMBER	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT TO HIM/HER
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 PLAN 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 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) ______

OFFICE VERIFICATIN

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

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

TOTAL FEE SUBMITTED

INSTRUCTIONS

All claims under this group benefits plan are submitted through the plan member. We may exchange personal information about claims with the plan member and a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims.

1.Have your dentist complete Part 1.
2.Employee completes Parts 2 and 3.
3.If you wish benefits to be paid directly to the dentist, sign the assignment portion of Part 1 above. Assignment of benefits is irrevocable. NexgenRx ay discuss details of this claim with the assignee.

Send this claim to:
NexgenRx Inc.
145 The West Mall
PO Box 110 U
Toronto, Ontario M8Z 5M4

DO YOU WANT ANY UNPAID BALANCE FROM THIS CLAIM REIMBURSED FROM YOUR HEALTH CARE SPENDING ACCOUNT (IF ELIGIBLE)? ☐ YES ☐ NO

PART 2 – EMPLOYEE/PLAN MEMBER/SUBSCRIBER

SUBSCRIBERS NAME ______
LAST NAME **FIRST NAME**

NexgenRx GROUP POLICY/PLAN NUMBER ______ **Division:**______

SUBSCRIBERS CERTIFICATE NUMBER ______

SUBSCRIBERS DATE OF BIRTH ______
DAY **MONTH** **YEAR**

EMPLOYER ______

PART 3 – PATIENT INFORMATION

1. PATIENT NAME ______
2. RELATIONSHIP TO INSURED ______
3. DATE OF BIRTH ______
   i. DAY MONTH YEAR

   IF CHILD INDICATE : STUDENT HANDICAPPED
4. IF STUDENT CHILD INDICATE SCHOOL ______
5. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE PLAN? ___ YES ___NO

   IF YES, POLICY NUMBER ______ SPOUSE'S DATE OF BIRTH ______
6. NAME OF OTHER INSURING AGENCY ______
   .
7. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? ___ YES ___NO
   IF YES, GIVE DATE AND DETAILS SEPARATELY
8. IF DENTURE, CROWN OR BRIDGE IS THIS THE INITIAL PLACEMENT? ___ YES ___NO
   GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT
9. IS ANY TREATMENT REQUIRED FOR OTHODONTIC TREATMENT? ___ YES ___NO
10. 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 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 pursue such other lawful remedies as we deem necessary.

OPDENT18E