

# DENTAL CLAIM FORM

## PART 1 - TO BE COMPLETED BY DENTIST

P A T I E N T	LAST NAME		FIRST NAME	UNIQUE NO.	SPEC.	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.  SIGNATURE OF PLAN MEMBER _____	
	ADDRESS			APT.	D E N T I S T			
	CITY	PROV.	POSTAL CODE					PHONE NUMBER

FOR DENTIST'S USE ONLY, FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION.

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY POLICY BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE COST OF THE 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 INSURANCE COMPANY/PLAN ADMINISTRATOR.

\_\_\_\_\_  
SIGNATURE OF PATIENT (PARENT/GUARDIAN)

\_\_\_\_\_  
OFFICE VERIFICATION / DENTIST'S SIGNATURE

DUPLICATE FORM

DATE OF SERVICE			PROCEDURE CODE	INT. TOOTH CODE	TOOTH SURFACES OR UNITS	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES
Y	M	D						

- INSTRUCTIONS**
- Have your dentist complete part 1.
  - Complete all questions in part 2.
  - Send form to **Coughlin & Associates Ltd.**



**Mailing Address:**  
P.O. Box 764  
Winnipeg, MB R3C 2L4

**Street Address:**  
175 Hargrave Street,  
Suite 100,  
Winnipeg, MB R3C 3R8

**Tel.:**  
local - (204) 942-4438  
toll free - 1-888-204-1234

**E-mail:**  
winwebmaster@coughlin.ca

**Fax:** (204)-943-5998

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E. & O.E.      TOTAL FEE SUBMITTED \_\_\_\_\_

## PART 2 - TO BE COMPLETED BY PLAN MEMBER

GROUP OR EMPLOYER \_\_\_\_\_

PLAN MEMBER'S FULL NAME \_\_\_\_\_

PERSONAL IDENTIFICATION NUMBER (P.I.N.) \_\_\_\_\_

LANGUAGE PREFERENCE      TELEPHONE NUMBER

ENGLISH       FRENCH

PLAN MEMBER'S ADDRESS \_\_\_\_\_

APT. \_\_\_\_\_

CITY \_\_\_\_\_      PROVINCE \_\_\_\_\_

POSTAL CODE \_\_\_\_\_      DATE OF BIRTH \_\_\_\_\_

YEAR    MONTH    DAY

**Are any dental benefits or services provided under any other group insurance or dental plan, Worker's Compensation or government plan?**

Yes       No

If yes, indicate member under other plan: If spouse indicate:      Self       Spouse

Name \_\_\_\_\_      DOB \_\_\_\_\_

Year    Month    Day

Name of other insuring agency or plan \_\_\_\_\_

Policy No. \_\_\_\_\_      P.I.N. \_\_\_\_\_

*N.B. For coordination of benefits, children must claim under the plan of parent with the earlier day and month of birth in the calendar year.*

### COMPLETE ONLY IF CLAIM IS FOR A DEPENDENT

DEPENDENT'S LAST NAME \_\_\_\_\_      FIRST NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_      RELATIONSHIP TO PLAN MEMBER \_\_\_\_\_

Year    Month    Day

If this claim is for a dependent child age 21 or over, what was the date the child last attended school on a full time basis? \_\_\_\_\_

Year    Month    Day

Name of school \_\_\_\_\_

1. IS THIS CLAIM DUE TO AN ACCIDENT?      YES       NO

DATE OF ACCIDENT \_\_\_\_\_

IF "YES" ATTACH DETAILS OF THE ACCIDENT.

2. IF TREATMENT INVOLVES THE PLACEMENT OF A CROWN / BRIDGE OR DENTURE.

IS THIS THE INITIAL PLACEMENT?      UPPER      YES       NO

LOWER      YES       NO

IF "NO", GIVE THE DATE OF PRIOR PLACEMENT AND ATTACH AN EXPLANATION.

YEAR    MONTH    DAY

DATE \_\_\_\_\_

I authorize Coughlin & Associates Ltd. to collect and exchange personal information about me and/or my dependants to process this claim and administer my group plan. I authorize Coughlin the use of my Social Insurance Number for the purposes of government reporting, identification and administration of my group benefits; Coughlin to exchange my personal information with the following persons, organizations or parties: Health care providers; financial institutions; government agencies; insurance companies; employers or former employers; my local union or plan trustees and auditors; and Coughlin to use the personal information on file to provide me with additional information regarding any benefits to which I am entitled. When providing personal information for my spouse and/or dependants, I confirm that I am authorized to act on their behalf. I agree that a photocopy or electronic copy of this Authorizations & Declarations section is as valid as the original.

I certify that the information given is true, correct and complete to the best of my knowledge.

PLAN MEMBER'S SIGNATURE \_\_\_\_\_

**Protecting your personal information** The administrator of your group benefit plan is Coughlin & Associates Ltd. At Coughlin, we recognize and respect every individual's right to privacy. When personal information is provided to us, we establish a confidential file that is kept in the offices of Coughlin, or the offices of an organization authorized by Coughlin. We use the information to administer the group benefit plan. We limit access to information in your file to Coughlin staff or persons authorized by Coughlin who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law.