Send completed forms with receipts to
Local 493 Benefit Services at:
584 Clinton Ave., Sudbury ON P3B 2T2
fax:705-674-6728
email:benefits493@liunalocal493.ca

STANDARD DENTAL CLAIM FORM

nexgenRx

PART 1 DENTIST

UNIQUE NO	SPEC.	PATIENTS OFFICE ACCOUNT NUMBER

PATIENT
FIRST NAME _____ LAST NAME _____
ADDRESS _____ APT # _____
CITY _____ PROVINCE _____ POSTAL CODE _____

DENTIST
PHONE NUMBER _____

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT TO HIM/HER

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) _____

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

FOR CARRIER USE

ALLOWED AMOUNT	INC	%	PATIENT'S SHARE

CHQ. NO. _____ DATE _____

DEDUCTIBLE	PATIENT PAYS	PLAN PAYS	

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

TOTAL FEE SUBMITTED

CLAIM NO.

INSTRUCTIONS 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 _____

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 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.