DENTAL CLAIM FORM

PART ONE - TO BE COMPLETED BY DENTIST

Unique No.	Spec.	Patient's Account No.

PATIENT

Name

Address

City Prov. Postal Code

Phone

DENTIST

Name

Address

City Prov. Postal Code

Phone

I hereby assign my benefits payable from this claim to the named dentist, and authorize payment directly to him/her.

Signature of Subscriber

For Dentist Use Only / Office Verification
(additional information, diagnosis, procedures or special consideration)

☐ Duplicate Form

I understand that the fees listed in this claim may not be covered or may exceed my plan benefits. I understand that I am financially responsible to my dentists 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.

Signature of Patient (Parent/Guardian)

Date Day Mo Yr	Procedure Code	Internal Tooth Code	Tooth Surface	Lab Charges	Total Charges	Date Day Mo Yr	Procedure Code	Internal Tooth Code	Tooth Surface	Lab Charges	Total Charges
						This is an accurate statement of services performed, and the total fee due and payable, E & OE.				Total Fee Submitted:	

PART TWO - TO BE COMPLETED BY EMPLOYEE

Name of Employee	Certificate Number / S.I.N.	Date of Birth (DD/MM/YY)
Name of Employer	Division (if applicable)	Group Policy/Plan Number

PART THREE - TO BE COMPLETED BY EMPLOYEE

Name of Patient	Relationship to Subscriber	Date of Birth (DD/MM/YY)

1 If patient is 19 years of age or older, indicate: ☐ Handicapped ☐ Student - Name of School: _____

2. Are any benefits or services provided from any other source? ☐ Yes ☐ No Spouse's Birthdate: _____

If YES, indicate the name of Insurance Agency or Plan: _____ Plan Number: _____

3. Is any treatment required for orthodontic purposes? ☐ Yes ☐ No

4. Is any treatment required as the result of an accident? ☐ Yes ☐ No
If YES, please provide date and details on separate sheet.

5. If denture, crown or bridge, is this initial placement? ☐ Yes ☐ No
If YES, please provide date of prior placement and reason for replacement on separate sheet.

I authorize release of any information, or record requested, with respect to this claim to ***Ten Star Group Benefit Specialists Inc.***, and certify that the information given is true, correct and complete to the best of my knowledge. Any personal information that we collect from you will be used to determine your entitlement to benefits under this plan. All personal information will be used for the stated reason for which it was collected. Any other use of this information requires further consent from you.

Employee Signature: _____ **Date:** _____

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TEN STAR Group Benefit Specialists Inc.™

Submit claims to: Ten Star Group Benefit Specialists Inc.
95 Hamilton Street North, Suite 2, P.O. Box 1490
Waterdown, Ontario L0R 2H0
Phone: (905) 689-7911 or toll-free (877) 836-7827
Fax: (905) 689-1885 or toll-free (866) 269-5510