STANDARD DENTAL CLAIM FORM

PART 1 DENTIST

UNIQUE NO.	SPEC.	PATIENTS ACCOUNT NO.

PATIENT

LAST NAME GIVEN NAME

ADDRESS

CITY PROVINCE POSTAL CODE

DENTIST

PHONE NO.

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

SIGNATURE OF SUBSCRIBER

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

DUPLICATE FORM ☐

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY PLAN BENEFITS. 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 VERIFICATION

Date of Service D	M	Y	Procedure Code	Tooth Code	Tooth Surfaces	Dentists Fee	Lab Charge	TOTAL CHARGES

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

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. Plan member 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.
4. SEND THIS CLAIM TO:

NB Pipe Trades Admin Office
5 Blizzard Street
Fredericton, NB E3B 8K3
506-459-6040

PART 2 PLAN MEMBER INFORMATION

GROUP NUMBER: _____ LOCAL NUMBER: _____ CERTIFICATE NUMBER: _____

PLAN NAME: _____

PLAN MEMBER NAME: _____ DATE OF BIRTH: _____/_____/_____
DAY MONTH YEAR

PLAN MEMBER ADDRESS: _____

At NexgenRx/NB Pipe Trades we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. For a copy of our Privacy Guidelines or if you have questions about our personal information policies and practices (including with respect to service providers), write to NexgenRx's Chief Privacy Officer or refer to www.nexgenrx.com.

I authorize NexgenRx/NB Pipe Trades, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations or service providers working with NexgenRx/NB Pipe Trades, located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. I certify that the information given is true, correct and complete to the best of my knowledge.

PLAN MEMBER'S SIGNATURE: _____ DATE: _____

PART 3 COORDINATION OF BENEFITS

1. Patient's relationship to you: _____ 2. Patients Date Of Birth: _____/_____/_____
DAY MONTH YEAR

3. If the patient is a child, does the patient reside with you? ☐ Yes ☐ No

4. If the child is over over: a) Is he/she a full-time student? ☐ Yes ☐ No

b) If student, how many hours per week at school? _____

c) Is he/she employed? ☐ Yes ☐ No If yes, how many hours worked per week? _____

5. Are you or any other member of your family entitled to benefits under any other plan? ☐ Yes ☐ No

If yes, name of family member insured: _____ Relationship to plan member: _____

Name of other insurance company: _____ Policy/Group Number: _____

6. Is this treatment required as the result of an accident? ☐ Yes ☐ No If yes, please attach details of the accident (ie date, location, how it happened)

7. Is a claim being made for Worker's Compensation Benefits? ☐ Yes ☐ No

8. If claim is for denture, crown or bridge, is this initial placement? ☐ Yes ☐ No If no, give date of prior placement and reason for replacement:

_____