

Accidental Dental Claim Form



Please answer all questions fully – it helps us to provide better service

Important - If the member is covered under any other Extended Health or Dental insurance plan, the expenses must be submitted to the Extended Health plan (Accidental Dental Benefit) and then to the Dental plan. If there is any unpaid balance, please attach their payment statement(s).

Note – This form can be completed in ink (please print), however, the form must be signed and dated by ALL parties and then the ORIGINAL, signed form in its entirety must be returned to **AXA Assurances Inc.** at any of the following addresses:

1075 Bay Street, Toronto, Ontario M5S 2W5
2020 University Street, Suite 700, Montreal, Quebec H3A 2A5
645 – 7th Avenue S.W., Suite 1400, Calgary, Alberta T2P 4G8

Emailed, faxed or photocopied forms (once completed) are unacceptable for claims purposes.

Part 1 – Dentist

Policy No.: 9226003

Unique No. _____ Spec. _____ Patient's Office Account Number _____

Patient's Name

Dentist's Name

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

Address _____

Address _____

Telephone No: () _____

Telephone No: () _____

Signature of Subscriber _____

For Dentist use only

Duplicate form

(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 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.

Signature of patient (parent / guardian) _____

Office Verification

Date of Service (D/M/Y)	Procedure Code	Intl. Tooth Code	Tooth Surfaces	Dentist's Fees	Laboratory Charges	Total Charges	For Carrier Use:			
							Allowed Amt.	Inc.	%	Patient's Share
This is an accurate statement of services performed and the total fee due and payable, E & OE.						Total Fee Submitted: \$ _____	Cheque No. _____ Date (D/M/Y) _____			
							Deductible	Patient Pays	Plan Pays	
							Claim Number _____			

Part 2 – Dentist's Supplementary Report

1. Description of damage _____

2. Is further treatment indicated? Yes No If **Yes**, please indicate :

Intl. Tooth Code	Treatment Indicated – use procedure code if possible	Estimated Date – Treatment (D/M/Y)

3. Describe further potential problems and indicate time frame. _____

4. A) How many teeth were injured? ____ B) Were these whole or sound teeth? Yes No C) How many of these teeth had fillings? ____
 D) How many of these injured teeth had crowns? ____ E) How many of these injured teeth had root canal treatment? ____
 F) If not whole or sound teeth, explain reason why _____

Dentist's Signature _____

Date

Part 3 – Dental Accident Supplementary Questionnaire for Insured Subscriber

Policy No.: 9226003

Date of accident D M Y Time of accident? a.m. p.m.

Where did accident occur? _____

Describe how accident occurred? _____

Nature of injury? _____

If taken to hospital, name of hospital? _____

Date admitted D M Y Time a.m. p.m.

Date discharged D M Y Time a.m. p.m.

Dentist's Name _____ Date first treated D M Y

Part 4 – Employee / Plan Member / Subscriber (if covered under other plans(s))

Your Name _____ Date of Birth D M Y

Group Policy / Plan Number _____ Division / Section Number _____

Employer _____

Name of insuring agency or plan _____

Part 5 – Patient Information

Patient _____ Relationship to Employee/Plan Member/Subscriber _____

Date of Birth D M Y If child, indicate Student Handicapped

If student, indicate school _____

Do you have coverage for dental expenses under any of the following:

Group Health Plan? Yes No Plan Name/Policy No. _____

Group Dental Plan? Yes No Plan Name/Policy No. _____

W.C.B. Plan? Yes No Plan Name/Policy No. _____

Government Plan? Yes No Plan Name/Policy No. _____

I certify that to the best of my knowledge that the statements made above are true, correct and complete.

Signature of Plan Member/Subscriber _____ Date D M Y

Please return completed claim form with the "Consent to collect, use and disclose personal information" form.

Part 6 – Policyholder / Employer (for completion only if applicable)

Date coverage commenced? D M Y Date terminated D M Y

Date dependent covered? D M Y

Policyholder _____

Address _____

Signature of Policyholder/Employer _____ Print Name _____

Position/Title _____ Date D M Y Telephone () _____