P.O. Box 10500, station Sainte-Foy, Quebec, QC, G1V 4H6

# DENTAL CLAIM FORM

## PART 1 - TO BE COMPLETED BY PROVIDER

| Licence No | Spec | Patient's Office Account No. |
|---|---|---|
| | | |

**PATIENT**

Patient Last Name First Name

Address Apt.

City Province Postal Code

**PROVIDER**

**Phone No**

**REMIT PAYMENT TO PROVIDER**

I hereby assign my benefits payable from this claim to the named provider and authorized payment directly to him/her

Signature of Participant

For provider'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 plan benefits. I understand that I am financially responsible to my provider for the entire treatment.

I also authorize the communication of information related to the coverage of services described in this form to the named provider.

Signature of Patient (Parent/Guardian)_____

| Date of Service YYYY MM DD | Procedure Code | Int'l Tooth Code | Tooth Surfaces | Provider's Fee | Laboratory Charges | Total Charges | Allowed Amount | Code |
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**This is an accurate statement of services performed and the total fee due and payable.**

**TOTAL FEE SUBMITTED**

**Provider Signature :**_____ **Date :**_____

**INSTRUCTIONS FOR CLAIM SUBMISSION:**

**Please carefully fill in all pertinent areas and sign the completed form. (Refer to SSQ Identification Card for correct patient information). Incomplete or incorrect claim forms will be returned or rejected and will result in a delay in reimbursement.**

## PART 2 - PARTICIPANT

**All claims must be submitted within 12 months of the date of service.**

**Participant's Name (Please Print)**

**Last Name** **First Name**

**SSQ Certificate Number**

**-00**

**Participant's Date of Birth**

**YYYY MM DD**

## PART 3 - PATIENT INFORMATION

**Patient's Name (Please print)**

**Last Name** **First Name**

Sex Female ☐ Male ☐

**Patient's Date of Birth**

**YYYY MM DD**

1. Patient: Relationship to Participant_____

If child, indicate: Student ☐ Handicapped ☐

If student, indicate school_____

2. Are any dental benefits or services provided under any other group insurance, dental plan, or Government Plan?

No ☐ Yes ☐

Name of other insuring Agency or Plan_____

If Yes, Policy No._____ Spouse Date of Birth_____

3. Is any treatment required as the result of an accident? If Yes, please complete the Dental Accident Report form. No ☐ Yes ☐

4. If denture, crown or bridge, is this initial placement? Give date of prior placement and reason for replacement. No ☐ Yes ☐

Date: _____ / _____ /_____

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

I authorize the release of any information or records required in respect of this claim to insurer /plan administrator and certify that the information given is true, correct and complete to the best of my knowledge.

**Signature of Participant**

**Date**_____

**YYYY MM DD**

**All information recorded on this form is confidential.**

**By signing this claim form and/or submitting actual receipts, I agree that the information provided on this form is complete and accurate. I understand that the information provided by me to SSQ Insurance about myself and my dependents, will be used by SSQ Insurance for claims adjudication and any other services necessary in the administration of our benefits which may include the exchange of information with other parties to administer this benefit claim. I am authorized by my spouse and/or dependents to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder.**

**SSQ Life Insurance Company Inc. is committed to keeping your information confidential.**