MDM Insurance Services Inc. STANDARD DENTAL CLAIM FORM

PART 1 DENTIST	UNIQUE NO.	SPEC.	Patient's Office Account No.	I hereby assign my benefits payable from this claim to the named dentist and authorize payment directly to him/her.
PATIENT		**DENTIST** Phone No.		**PLEASE PAY SUBSCRIBER** Signature of subscriber

FOR DENTIST USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATIONS.

❒Duplicate Form

I understand the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand 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 Day	Mo	Yr	Procedure Code	Intl Tooth Code	Tooth Surfaces	Dentist's Fee		Laboratory Charge		Total Charges	

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

TOTAL FEE SUBMITTED

PART 2 EMPLOYEE/PLAN MEMBER/SUBSCRIBER

GROUP POLICY DIVISION NO. EMPLOYEE NAME (Please Print) _____

EMPLOYER EMPLOYEE DATE OF BIRTH (MM/DD/YY) _____

PART 3 PATIENT INFORMATION

1. PATIENT: RELATIONSHIP TO EMPLOYEE/PLAN MEMBER/SUBSCRIBER: _____ DATE OF BIRTH (MM/DD/YY) _____
   IF CHILD 0 YEARS OR OLDER: STUDENT? NO___ YES___ SCHOOL ATTENDED _____
   HANDICAPPED? NO___ YES___ HAS PROOF BEEN SUBMITTED? NO___ YES___

2. ARE ANY DENTAL BENEFITS PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN, WSIB OR GOV'T PLAN? NO___ YES___
   POLICY NO. _____ SPOUSE DATE OF BIRTH (MM/DD/YY) _____ NAME OF OTHER INSURANCE AGENCY OR PLAN _____

3. IF YOU ALSO HAVE A HEALTH SPENDING ACCOUNT, SHOULD ANY UNPAID BALANCE OF THIS CLAIM BE REIMBURSED UNDER YOUR HEALTH SPENDING ACCOUNT BEFORE BEING CONSIDERED UNDER YOUR SPOUSE'S PLAN? NO___ YES___

4. IS ANY TREATMENT THE RESULT OF AN ACCIDENT? NO___ YES___ IF YES GIVE DATE AND DETAILS SEPARATELY.

5. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? NO___ YES___ IF NO, DATE OF PRIOR PLACEMENT (MM/DD/YY) _____
   AND REASON FOR REPLACEMENT: _____

6. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? NO___ YES___

I UNDERSTAND THAT MDM INSURANCE SERVICES INC. IS COMMITTED TO THE PROTECTION OF PRIVACY AND SECURITY OF THE PERSONAL INFORMATION PROVIDED IN CONNECTION WITH THIS CLAIM AND THAT THE SUBMISSION OF FALSE OR INCOMPLETE INFORMATION MAY CAUSE THE DELAY OR DENIAL OF THIS CLAIM. THE INFORMATION THAT I HAVE PROVIDED IS COMPLETE AND ACCURATE AND I AUTHORIZE ANY PERSON OR ORGANIZATION WITH THE INFORMATION RELEVANT TO THIS CLAIM TO RELEASE THAT INFORMATION AS MAY BE REQUIRED FOR THE INVESTIGATION AND ADMINISTRATION OF THIS CLAIM. I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED TO THE COVERAGE OF SERVICES DESCRIBED IN THIS FORM TO THE NAMED DENTIST. I CONFIRM THAT I AM AUTHORIZED TO ACT ON BEHALF OF THE PERSON FOR WHOM THIS CLAIM IS MADE. ANY COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

SIGNATURE OF EMPLOYEE/PLAN MEMBER/SUBSCRIBER DATE (MM/DD/YY)

Submit your claim by Mail: **MDM Insurance Services Inc. P.O. Box #970, Guelph, Ontario N1H 6N1**

E-mail: **inquiry@mdm-insurance.com** Fax: **519-836-4909**