La Capitale
Insurance and Financial Services

Le Delta II Building
2875 Laurier Blvd. - Suite 100
Sainte-Foy, Québec G1V 2M2
Email:

Phone: (418) 644-4200
1 800 463-4856
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prest.sante@lacapitale.com

DENTAL INSURANCE CLAIM FORM

INFORMATION ON THE PARTICIPANT

A.

Group: Employer:

Identification No.:

If the information contained in Section A is incorrect or incomplete, please fill in Section B.

B.

Name: _____

Address: _____

_____

Postal Code: _____ Phone No.: _____

Group: Employer:

Identification No.: _____

IMPORTANT

1. For dependent child aged 18 to 26 years old, fill in section 2 on this form.
2. If dental services are necessary as the result of an accident, fill in section 3 on this form and include the **x-ray(s)**.
3. Your claim form must be filed in within 12 months from the date dental expenses were incurred and services received.

1- INFORMATION ON THE PARTICIPANT:

Employer's name: _____

Participant telephone number: at home _____

at work, if applicable _____

Participant date of birth: _____ (Year / Month / Day)

INFORMATION ON THE PATIENT:

Relationship with the participant:

❑ spouse ❑ other ❑ child

Patient date of birth: _____ (Year / Month / Day) _____ (Given name)

Are any dental benefits or services provided under any other group insurance or dental plan, or government plan? ❑ No ❑ Yes

Policy No: _____

Name of insuring agency: _____

Spouse date of birth: _____ (Year / Month / Day)

2- STUDENT CERTIFICATE FOR CHILD AGED OVER 17 OR 20 YEARS OLD ACCORDING TO YOUR POLICY

I hereby certify that my child, _____ (First name) is unmarried and attends the secondary school, college or university _____ (Name of institution) for the ❑ fall session _____ (Year), ❑ winter session _____ (Year), as a student on a ❑ full time basis or ❑ partial-time basis.

3- DENTAL SERVICES REQUIRED AS THE RESULT OF AN **ACCIDENT**

❑ No ❑ Yes If yes, indicate the date, _____

give some details, and enclose the **X-RAY(S)**. _____

I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO THE INSURER AND CERTIFY THAT THE INFORMATION GIVEN IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE

_____ (Year / Month / Day) _____ (Participant's signature)

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

2004-11-18

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DENTAL CLAIM FORM

STANDARD FORM
APPROVED BY QUÉBEC
DENTAL SURGEONS ASSOCIATION

DENTIST

Name:

Address:

City, Prov.:

Postal Code:

Phone No.: Licence:

N.B.: An official receipt or the professionnal's seal is required for reimbursement.

Patient's Last Name Given Name(s)

Address Apt.

City Province

Postal Code Phone No.

Date of treatment Year	Month	Day	Internat Tooth Code	Procedure code	Surface or Sextant	Laboratory Charge	Dentist's fee	Total Charge

This is an accurate statement of services performed and fees charged, or of services to be performed and fees to be changed in the case of a treatment plan except errors and omissions.

Dentist's signature

Total Fees Submitted

Date Year Month Day Total

❑ 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 cost of the treatment. I authorize release of the information contained in this form to my insurance company or plan administrator.

Signature of patient (or parent / guardian)

❑ **Treatment Plan**

This estimate is valid for 60 days only.
Fees do not cover complications that may occur during and after treatment.
Laboratory costs are approximate.

No date of treatment should appear on this form.

Reserved for dentist's use for additional information on diagnosis, procedures complications and special considerations.

IMPORTANT

The participant must duly fill in the reverse of this form and sign it.

N.B.: An official receipt or the professionnal's seal is required for reimbursement.

2004-11-18