Great-West Life

STANDARD DENTAL CLAIM FORM



Canadian Life and Health Insurance Association

| | DA | OT 4 | BEN | TICT | | | | | | | | 07 | 0 54 | 0 75 | $51_{\overline{c}.}$ | PATIE | NT'S OFFICE ACCOUNT NO. I HEREBY ASSIGN MY BENEFITS | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------|-----------------------------------------|----------------------------|---------------|---------------------------|--------------------------------|---------------------------------------------|--------------------------|---------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|-----------------------------------------------------------|-------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| | P LAST NAME GIVEN NAM | | | | | | | | | | | Dr. Conny Athanasopoulos PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE | | | | | | | |
| | A | | | | | | | | | | | H | Unit 4A - 140 Meadowood Drive | | | | | | |
| | 1 ADDRESS API. | | | | | | | | | | | | Winnipeg, Manitoba R2M 5L8 | | | | | | |
| | N CITY PROV. POSTAL CODE | | | | | | | | | | | (204) 253 1260 | | | | | | | |
| | T FOR DENTIST'S USE ONLY, FOR ADDITIONAL INFORMATION, DIAGNOSIS | | | | | | | | | | NOCIO | | | | | | | | |
| | PROCEDURES, OR SPECIAL CONSIDERATION. | | | | | | | | | | 1140313, | PLAN BENEFITS, I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE | | | | | | | |
| | | | | | | | | | | | | TREATMENT. I ACKNOWLEDGE THAT THE TOTAL FEE OF \$ S 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 OF RELATED | | | | | | |
| | | | | | | | | | | | | TO TH | TO THE COVERAGE OF SERVICES DESCRIBED IN THIS FRAM TO THE NAMED DS 19 1 | | | | | | |
| | DUDUGATERODIA | | | | | | | | | | | | | | | | | | |
| | DUPLICATE FORM DATE OF SERVICE PROCEDURE INTLITOOTH TOOTH DENTIST'S | | | | | | | | | | | | DIGNAURE ON ALE | | | | | | |
| (| | | NO. YR. COL | | | IL IN | CODE | SURFACES | DENTIST'S FEE | | | CHARGE | | TO | TAL CH | ARGES | INSTRUCTIONS All claims under this group benefits plan are submitted through | | |
| | | | | + | _ | + | | MON | TH | a | LOR | TH | DNT | 10 | 1 | 25 | the plan member. We may exchange personal information | | |
| | | | | | | | | | | | 1 | | | | | | about claims with the plantage his or her behalf when no | | |
| | | | | | | | | | | 17 | 23 | | | | | | mutually manage the claims. 1. Have your dentist complete Part 1. | | |
| | | | | | | | | | | | | | | | | | 2. Employee completes Parts 2 and 3. | | |
| | | - | 1 | _ | _ | 44 | | X | - | | | - - - - - - - - - | | 44 | | | If you wish benefits to be paid directly to the dentist, sign the assignment portion of Part 1 above. Assignment of benefits | | |
| | | - | | _ | - | | | 81 | | | | | | 4 | | | is irrevocable. Great-West Life may discuss details of this claim with the assignee. | | |
| | | - | | | - | + | | INI | TI | AL | - 0 | KI | HOOC | 771 | 16 | | 4. Send this claim to: | | |
| | | - | | | - | + | | - | - | | \dashv | | ┪—— | ++ | | - 00 | | | |
| 30 | - | - | | | _ | + | | | - 1 | 72 | 4- | +++ | | ++ | 1,2 | 50° | | | |
| 30 | | - | | | _ | ++ | | | _ | ++ | | | | ++ | * 7 | 4 | 4 | | |
|)I | | | | | - | ++ | | | - | ++ | | +-+ | | ++ | ^ (|)R | | | |
| | THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED | | | | | | | | | | | | | | 10 | 2-00 | | | |
| | AND THE TOTAL FEE DUE AND PAYABLE, E. & O.E. TOTAL FEE SUBM | | | | | | | | | | | | MITTE |) / | / 2 | 25.00 | | | |
| | PART 2 EMPLOYEE INFORMATION | | | | | | | | | | | | | | | | | | |
| Plan Number Division Number Employee Identification Number | | | | | | | | | | | nployee Identification Number | | | | | | | | |
| Plan Name | | | | | | | | | | | | | | | | | | | |
| W | Employee Name | | | | | | | | | | | | | | | | | | |
| 1/2 | | | | | | | | | | | | | Day Month Year | | | | | | |
| At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for your claim and administering the group benefits plan. For a copy of our Privacy Guidelines, or if you have questions about our plant and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to way | | | | | | | | | | | | | | | ou have questions about our personal information policies | | | | |
| INFORM | be pe | uthor nefits rson | rize G s or ot al info | ireat-V herbe ormati | Vest nefit | Life, a sprog hen r | any hea Irams, d lecessa | althcare pro other organ any for thes | ovide iizati se pi | ons, c | plan orserv es. I u | admir rice pro unders | nistrator oviders stand th | r, other workingt pe | er insur ing with ersonal | rance or Great- informa | reinsurance companies, administrators of government West Life, located within or outside Canada, to exchange ation may be subject to disclosure to those authorized act, and complete to the best of my knowledge. | | |
| 3 | un | uer a | applic | aule la | W WI | unin c | THIO! | | / § | | n lh | e info | rmation | give | n is tru | e, corre | ect, and complete to the best of my knowledge. | | |
| Employee's Signature | | | | | | | | | | | | | Date * | | | | | | |
| PART 3 COORDINATION OF BENEFITS 1. Patient's relationship to you | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | 2. Patient's date of birth /Month / Year | | | | | |
| 4. If the child is over 18: a) Is he she a full-time student? Yes No | | | | | | | | | | | | Day Month Year | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| | | b) Witudent, how many hours per week at school? | | | | | | | | | | | | | | | | | |
| | | Yes No If yes, how many hours worked per week? | | | | | | | | | | | | | | | | | |
| | 5. a) Are you or any other member of your family entitled to ben | | | | | | | | | | | | | | | | | | |
| | | | If yes | name | of fe | amily | membe | r insured _ | ************ | | ~~~~ | | Relationship to employee | | | | | | |
| | | | Name | of oth | ier ly | suran | ce con | pany | | | | | Policy Number | | | | | | |
| | | b) | is any | mem | ber d | T you | family | (other than |) you | irself) | insur | ed as | an emp | oloyee | under | this pla | an? ☐ Yes ☐ No | | |
| | - | c) | II yes | toyque | estion | 1s 5 a |) or b), | and the pa | tient | isa | depen | dent c | hild, pl | ease | orovide | spouse | e's Date of Birth / / | | |
| | D. | | | | | | | | | | | | | | | | Day Monin Year | | |
| | 7 | | | | | | | plain how r's Comper | | | | | | ۳٦ | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 8. If claim is for denture, crown or bridge, is this initial placement? Yes No If no, give date of prior | | | | | | | | | | | ale of prior placement and reason for replacement. | | | | | | | | |
| | imagha | | *************************************** | | | | | | | | | | | | | | | | |