Cowan

DENTAL CLAIM FORM

Reset Values

You may fill out the form online and print it or print the form and fill it out by hand.

DENTIST

PATIENT

Last Name Given Name

Address Apt.

City Prov. Postal Code

DENTIST

Unique Nº Spec. Patient's office account Nº

Telephone:

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

Signature of subscriber

For dentist's use only. For additional information, diagnosis, procedures, or special consideration.

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 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 or guardian) Office verification/Dentists signature

Date of service Day Month Year	Procedure code	Inil. tooth code	Tooth surfaces	Dentist's fee	Laboratory charge	Total charges

This is an accurate statement of services performed and the total fee due and payable, E &

TOTAL FEE SUBMITTED

REMINDER

PLEASE REFER TO YOUR EMPLOYEE SUMMARY OF BENEFITS TO CONFIRM THE AMOUNT OF TIME YOU HAVE TO SUBMIT A CLAIM.

THIS FORM MUST BE COMPLETED IN FULL. INCOMPLETE FORMS WILL BE RETURNED TO YOU, WHICH WILL DELAY THE PROCESSING OF THE CLAIM.

EMPLOYEE STATEMENT

We recommend that any service exceeding $500 be approved by the insurer before the treatment begins.

Group Contract Number _____ Certificate Number _____

Employer _____

Employee Last name and given name _____ Date of Birth : day _____ / month _____ /year _____ Sex F ☐ M ☐

Employee Address: _____ **WOULD YOU LIKE YOUR CLAIMS PAYMENTS DEPOSITED DIRECTLY INTO YOUR BANK ACCOUNT? Yes** ☐, I am attaching a void cheque in order to benefit from that service. Once you have provided a void cheque, only send another void cheque if you change your bank information.

COORDINATION OF BENEFITS

Does your spouse and/or children have coverage under any other medical plan or contract? ☐Yes ☐No If yes, please complete the following:

Spouse's date of birth (D/M/Y) _____ Insurance company, policy number and certificate number _____

PATIENT INFORMATION

1. Patient's relationship to insured: ☐Member ☐Spouse ☐Child
2. Patient's date of birth: day _____ / month _____ /year _____
3. If this claim is for a child 21 years of age or older please indicate the following:
   Is the child handicapped? ☐
   Is the child a full-time student? ☐
4. Is this treatment the result of an accident? ☐Yes ☐No If yes, please complete the following:
   Date of the accident _____ Location of accident: ☐Home ☐Work ☐Other
   Explain how the accident occurred:_____
5. If this claim is for dentures, crowns or bridges, is this the initial placement? ☐Yes ☐No
   If no, please indicate the date of the prior placement and reason for replacement: Date _____ Reason _____

AUTHORIZATION

Personal information we collect from you is kept in strict confidence and will be used to assess your claim and to administer the group benefit plan. I authorize the use of my certificate number as an identification number where it is required in the administration of my group benefit plan. I authorize Cowan, any healthcare provider, my plan administrator, other insurance companies, other organizations, or benefit service providers working with Cowan to exchange information when necessary to assess my claim and to administer the group benefit plan. I certify that the information given is true, correct and complete to the best of my knowledge.

Signature of employee _____ **Date** _____

MAIL YOUR COMPLETED FORM TO THE FOLLOWING ADDRESS:

Cowan Insurance Group
700-1420 Blair Place
Ottawa, Ontario K1J 9L8
Telephone: 1-888-509-7797 or 1-613-741-3313