

# SEAFARER'S MEDICAL PLAN

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# STANDARD DENTAL CLAIM FORM



Canadian Dental Association

<b>PART 1 - DENTIST</b>			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.
P A T I E N T	LAST NAME _____ GIVEN NAME _____ ADDRESS _____ APT. _____ CITY _____ PROV. _____ POSTAL CODE _____	D E N T I S T	NAME _____ ADDRESS _____ TELEPHONE _____	
SIGNATURE OF SEAFARER OR SPOUSE _____				

FOR DENTIST'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 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 THE SEAFARERS' MEDICAL PLAN ADMINISTRATOR.

SIGNATURE OF SEAFARER OR SPOUSE \_\_\_\_\_

OFFICE VERIFICATION / DENTIST'S SIGNATURE \_\_\_\_\_

DUPLICATE FORM

DATE OF SERVICE			PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES	FOR SEAFARERS' MEDICAL PLAN USE	
DAY	MO.	YR.								
THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE.						<b>TOTAL FEE SUBMITTED</b> _____				

## INSTRUCTIONS FOR CLAIM SUBMISSION

1. HAVE THE ATTENDING DENTIST COMPLETE PART 1.
2. COMPLETE PARTS 2 AND 3 BELOW.
3. COMPLETE A BLUE CLAIM FORM (STATEMENT BY THE SEAFARER).
4. RETURN BOTH FORMS TO THE SEAFARERS' MEDICAL PLAN.

## PART 2 - SEAFARER INFORMATION

NAME OF SEAFARER : \_\_\_\_\_ UNION N° \_\_\_\_\_ SOCIAL INSURANCE N° \_\_\_\_\_

## PART 3 - PATIENT INFORMATION

1. PATIENT : RELATIONSHIP TO SEAFARER \_\_\_\_\_  
 DATE OF BIRTH: DAY \_\_\_\_\_ MONTH \_\_\_\_\_ YEAR \_\_\_\_\_
2. IF CLAIM IS FOR DEPENDENT CHILD, IS THAT CHILD PERMANENTLY DISABLED?  YES  NO   
 MARRIED?  YES  NO
3. IF CLAIM IS FOR SPOUSE, IS HE/SHE COVERED BY ANY OTHER INSURANCE FOR DENTAL CARE?  YES  NO   
 IF "YES", CLAIM MUST BE SUBMITTED TO THE OTHER INSURANCE PLAN AND NOT TO THE SEAFARERS' MEDICAL PLAN.
4. IS ANY OF THE ABOVE WORK FOR ORTHODONTIC PURPOSES?  YES  NO
5. A) IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT?  YES  NO   
 GIVE DATE AND DETAILS \_\_\_\_\_  
 B) IS CLAIM BEING MADE FOR WORKERS' COMPENSATION BENEFITS?  YES  NO
6. IF THE TREATMENT INVOLVES THE PLACEMENT OF A DENTURE:  
 A) IS THIS THE INITIAL PLACEMENT?  
 UPPER  YES  NO   
 LOWER  YES  NO   
 B) IF "NO" GIVE THE DATE OF PRIOR PLACEMENT AND THE REASON FOR REPLACEMENT \_\_\_\_\_  
 C) DATE OF EXTRACTIONS \_\_\_\_\_
7. I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO THE SEAFARERS' MEDICAL PLAN ADMINISTRATOR AND CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.  
 SIGNATURE OF SEAFARER OR SPOUSE: \_\_\_\_\_  
 DATE: DAY \_\_\_\_\_ MONTH \_\_\_\_\_ YEAR \_\_\_\_\_