

**INFORMATION ON THE PARTICIPANT**

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

**A.**

Group: \_\_\_\_\_  
 Identification No.: \_\_\_\_\_

Employer: \_\_\_\_\_

**B.**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_

Group: \_\_\_\_\_ Employer: \_\_\_\_\_

Identification No.: \_\_\_\_\_

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

**1- INFORMATION ON THE PARTICIPANT:**

Employer's name: \_\_\_\_\_

Participant's telephone number: at home \_\_\_\_\_  
 at work \_\_\_\_\_

Participant's date of birth \_\_\_\_\_  
 Y M D

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: \_\_\_\_\_

**INFORMATION ON THE PATIENT:**

Relationship with the participant:

spouse  other  child

Patient's date of birth \_\_\_\_\_  
 Y M D First name \_\_\_\_\_

Spouse's date of birth \_\_\_\_\_  
 Y M D

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

I hereby certify that my child \_\_\_\_\_ is unmarried and attends the secondary school, college or university \_\_\_\_\_  
 First name  
 Name of institution for the  fall session \_\_\_\_\_, or  winter session \_\_\_\_\_, as a day student on a full time basis.  
 Year Year

**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.

\_\_\_\_\_  
 Y M D

Participant's signature

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL.

(DENTAIRE-A) CPRDA1 (2013-01-09)

**DENTAL CLAIM FORM**  
 STANDARD FORM  
 APPROVED BY QUÉBEC  
 DENTAL SURGEONS ASSOCIATION

|  |  |
|--|--|
| <p>D E N T I S T</p> <p>Name: _____</p> <p>Address: _____</p> <p>City, province: _____</p> <p>Postal Code: _____</p> <p>Phone No.: _____      Licence: _____</p> | <p>Patient's Last Name      First Name(s)</p> <hr/> <p>Address      Apt.</p> <hr/> <p>City      Province</p> <hr/> <p>Postal Code      Phone No.</p> <hr/> |
|--|--|

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

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

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

|   |                             |      |       |     |       |
|---|-----------------------------|------|-------|-----|-------|
| <p>This is an accurate statement of services performed and fees charged, or of services to be performed and fees to be charged in the case of a treatment plan except errors and omissions.</p> <p align="center">_____<br/>Dentist's signature</p> <p><br/></p> <p>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.</p> <p align="center">_____<br/>Signature of patient (or parent/guardian)</p> | <b>Total Fees Submitted</b> |      |       |     |       |
|   | Date                        | Year | Month | Day | TOTAL |
| <input type="checkbox"/> <b>DUPLICATE FORM</b>  |                             |      |       |     |       |
| <input type="checkbox"/> <b>Treatment Plan</b> <p>This estimate is valid for 60 days only.<br/>                 Fees do not cover complications that may occur during and after treatment.<br/>                 Laboratory costs are approximate.</p> <p><b>No date of treatment should appear on this form.</b></p>  |                             |      |       |     |       |

**IMPORTANT**

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

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