



DENTAL CLAIM FORM

SUBMIT TO: 3227 Roblin Boulevard, Winnipeg MB R3R 0C2

FAX TO: 204-488-6008 **SCAN & E-MAIL TO:** info@siriusbenefits.ca

INQUIRIES: 1.800.663.8833

The personal information we collect from you is kept in strict confidence and will be used to assess your claim.

PATIENT DETAILS			DENTIST UNIQUE NUMBER:			ASSIGNMENT OF BENEFITS		
Name:			Name:			I hereby assign my benefits payable from this claim and authorize payment directly to the named Dentist. EMPLOYEE SIGNATURE: X _____		
Address:			Address:					
City/Province:			City/Province:					
Postal Code:			Postal Code: Phone:					

DATE OF SERVICE			PROCEDURE CODE	TOOTH CODE	TOOTH SURFACE	DENTIST FEE	LAB CHARGE	TOTAL FEE
DAY	MONTH	YEAR						

INSURANCE INFO:
Employee Name: _____
Birthdate: dd/mm/yyyy Gender: _____
Employer: _____
GROUP #: _____ CERT#: _____
Relationship to Patient: _____
Patient Birthdate: dd/mm/yyyy

CO-INSURANCE/SECOND PAYOR INFO:
Name of Family Member Insured: _____
Birthdate: dd/mm/yyyy Gender: _____
Relationship to Patient: _____
Name of Company: _____
GROUP #: _____ CERT#: _____

DENTIST USE ONLY:

- Treatment resulting from: Accident Workplace illness or injury
Details: _____
- Treatment involving: Denture Crown Bridge
Initial Placement Date & Reason for Replacement: dd/mm/yyyy
- Additional Information or Special Consideration:

This is an accurate statement of services performed and the total fee due and payable, errors and omissions accepted.

DENTIST SIGNATURE: X _____

AUTHORIZATION:

I authorize Sirius Benefit Plans, its advisors and service providers, any healthcare provider, other insurance companies, other organizations, or benefit service providers to exchange information when necessary to assess my claim and administer the group benefit plan.

I certify the answers given are true, correct and complete to the best of my knowledge. If this claim is being made on behalf of my spouse or dependents, I am authorized to disclose information about them, for the purpose of assessing and paying a benefit, if any.

I understand that the fees listed in this claim may not be covered or may exceed my insurance benefits. I understand that I am financially responsible for the entire cost of services received and that this claim is for reimbursement of eligible charges.

EMPLOYEE SIGNATURE: X _____