Green Shield CANADA
Where quality is more than a claim

DENTAL CLAIM FORM

Carleton University Students' Association (CUSA)
Graduate Students' Association (GSA)

Please send claim to:
PO Box 1608, Windsor, Ontario N9A 7G1
Attn: Dental Department or
CUSTOMER SERVICE CENTRE 1-888-711- 1119

Group # 24832

PART 1 - DENTIST

PATIENT

Patient Last Name | First Name

Address | Apt.

City | Province | Postal Code

DENTIST

Unique No | Spec | Patient's Office Account No.

Phone No

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

Signature of Student

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 provider 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 Student _____

Office Verification

Date of Service DAY MO YR	Procedure Code	Int'l Tooth Code	Tooth Surfaces	Dentist's Fee	Laboratory Charge	Total Charges	Allowed Amount	Code
This is an accurate statement of services performed and the total fee due and payable, E & OE.				**TOTAL FEE SUBMITTED**				

INSTRUCTIONS FOR CLAIM SUBMISSION

Please carefully fill in all pertinent areas and sign the completed claim form. (The prefix CAR should be entered before student id for electronic submissions.

Incomplete or incorrect claim forms will be returned or rejected and will result in a delay in reimbursement.

PART 2 - STUDENT MEMBER

Student Name (Please Print)

Last Name | Given Names

Student Identification Number

CAR- **-00**

Student's Date of Birth

Day | Mo | Yr

PART 3 - PATIENT INFORMATION

Patient's Name (Please Print)

Last Name | First Name | Middle Initial

Date Submitted

All claims must be submitted within 12 months of the date of service.

Patient's Date of Birth

Day | Mo | Yr

1. Patient: Relationship to Student _____
2. Are any dental benefits or services provided under any other group insurance or dental plan, W.S.I.B. or Government Plan?
   No ☐ Yes ☐
   If Yes, Policy No. _____
3. Is any treatment required as the result of an accident? If Yes, give date and details separately. No ☐ Yes ☐
4. If denture, crown or bridge, is this initial placement? Give date of prior placement and reason for replacement. No ☐ Yes ☐
5. Is any treatment required for orthodontic purposes? No ☐ Yes ☐

Spouse Date of Birth _____

Name of other Insuring Agency or Plan _____

By signing this claim form and/or submitting actual receipt, I agree that the information provided is complete and accurate, to the best of my knowledge. I authorize Green Shield Canada to exchange information with other parties as required and only when the information is needed to administer this benefit claim and/or to confirm the accuracy of this information.

All information recorded on this form is confidential.

Signature of Student _____ **Date** _____ **Day Month Year**

The cost, if any, of obtaining this information is at the expense of the Patient/Dentist