MAJOR

Claims Services, Major Plan, 763 St-Joseph Blvd, Gatineau, Qc, J8Y 4B7

DENTAL CLAIM FORM

(YOU CAN USE THE DENTIST FORM)

Please fill out all the appropriate boxes. Erroneous or incomplete forms will be returned or rejected and will result in delays for the reimbursement. **YOU MUST SIGN SECTION 3 OF THE PRESENT FORM OTHERWISE THE FORM WILL NOT BE PROCESSED!** Visit Major Plan website to learn about your coverage elements at www.planmajor.ca

SECTION 1 – TO BE COMPLETED BY DENTAL OFFICE

PATIENT

Last Name First Name

Address App.

City Province Postal Code

Unique No (dentist) Spec. Patient's Account No

DENTIST

Telephone

REMIT PAYMENT TO THE DENTAL OFFICE

I hereby **cedes to the supplier** named in the present the benefits payable under the reimbursement claim and I agree that **the be paid directly to them.**

Signature of Subscriber (member of the Plan)

Dentist's use only for additional information, diagnosis, procedures or special considerations.

I understand that the fees listed in this claim may not be covered 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 fees are accurate and have been charged to me for services rendered. I authorize release of the information contained in this claim to my insurer.

Signature of patient (parent or guardian) _____

Treatment Date AAAA MM DD	Procedure Code	Teeth int. code	Teeth Surfaces	Supplier Fees	Laboratory Fees	Total Fees	Admissible Amount (Reserved To Major Plan)	Code

This is an accurate statement of services performed and the total fees due and payable.

Total Fees Submitted

Dentist's signature: _____ **Date :** _____

SECTION 2 – INFORMATION ON THE SUBSCRIBER (the plan subscriber)

You must submit your services requests within 12 months of the service date.

Name of the subscriber (in print format)

Last Name **First Name**

Permanent code of the subscriber

Date of birth of the subscriber

YYYY MM DD

SECTION 3 – INFORMATION ON THE PATIENT

Name of the patient (in print format)

Last Name **First Name**

Sex F ☐ M ☐

Date of birth of the patient

1. Patient : relationship with the subscrober _____

If the subscriber is the patient, leave this line blank.

2. Are these dental treatments covered by another group insurance plan or dental plan, or by a government insurance plan?

No ☐ Yes ☐

Name of the other insurance or plan _____

Policy Number_____ Spouse date of birth _____

3. Are the treatments required as the result of an accident? If yes, please fill out the Accident Report Form. (90 jours). No ☐ Yes ☐

4. If the treatment include a denture, crown or bridge is this the initial placement? If not, give the date of prior placement, and the reasons for replacement. No ☐ Yes ☐

Date:_____/_____/_

5. Are orthodontics treatments required? No ☐ Yes ☐

I authorize the release of any information or records requested in respect of this claim to the insurer/plan administrator and certify that the information given is true, accurate and complete to the best of my knowledge.

Date _____

All the information contained on this form is confidential.

Subscriber's signature **YYYY MM DD**

By signing this claim form and (or) by sending the original receipts, I confirm that the information on this form are complete and accurate. I understand that the information I submitted to Major Plan on myself and my dependents will be used by Major Plan for the evaluation of my claims requests of as well as any other necessary services in the administration of our claims which might include exchanging information with other parties to administer this claim request. My spouse and (or) my dependents agrees also authorize myself to disclose and receive information related to them, which will be used for that purposes.