



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	Unique No (dentist) _____ Spec. _____ Patient's Account No _____	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.
P Last Name _____ First Name _____ A _____ T Address _____ App. _____ I _____ E City _____ Province _____ Postal Code _____ N _____ T _____	D E N T I S T Telephone _____	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 <small>(Reserved To Major Plan)</small>	Code

This is an accurate statement of services performed and the total fees due and payable.	Total Fees Submitted _____ Dentist's signature: _____ Date : _____
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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)		Permanent code of the subscriber	Date of birth of the subscriber
Last Name _____ First Name _____			YYYY MM DD

SECTION 3 – INFORMATION ON THE PATIENT		You must submit your services requests within 12 months of the service date.	
Name of the patient (in print format)		Sex	Date of birth of the patient
Last Name _____ First Name _____		F <input type="checkbox"/> M <input type="checkbox"/>	
1. Patient : relationship with the subscriber _____		3. Are the treatments required as the result of an accident? If yes, please fill out the Accident Report Form. (90 jours).	No <input type="checkbox"/> Yes <input type="checkbox"/>
If the subscriber is the patient, leave this line blank.		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 <input type="checkbox"/> Yes <input type="checkbox"/>
2. Are these dental treatments covered by another group insurance plan or dental plan, or by a government insurance plan? No <input type="checkbox"/> Yes <input type="checkbox"/>		5. Are orthodontics treatments required?	No <input type="checkbox"/> Yes <input type="checkbox"/>
Name of the other insurance or plan _____		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.	
Policy Number _____ Spouse date of birth _____		_____ Date _____ YYYY MM DD	

All the information contained on this form is confidential. **Subscriber's signature** _____

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.