Standard Dental Hygiene Claim Form

Top section of form is completed by dental hygienist :

CLIENT

Last name:	
First name:	
Address:	
Unit/Apt#:	City:
Prov:	Postal Code:

DENTAL HYGIENE PRACTICE

CDHO Registration #	
Name:	
Address:	
Suite#:	City:
Prov:	Postal Code:
Telephone:	Fax:

I hereby assign my benefits payable from this claim to the dental hygienist identified here and authorize payment directly to him/her.

_____

(signature of subscriber)

For additional notes, assessment, special considerations:

I understand that the fees listed in this claim may not be covered by my plan or may exceed the benefits of my plan. I acknowledge that I am responsible for the total fee shown below to the dental hygienist identified above and further acknowledge that the said fee is accurate. I agree to the release by the dental hygienist of any information necessary with respect to this claim to my insurance company or plan administrator.

_____

(signature of client/parent/guardian)

Service provided:

Date of service day	mo	yr	Description of service provided	Procedure code	Intl. Tooth code	Dental hygienist's fee	Laboratory or Expense charge	Total

This is an accurate statement of services performed and the total fee dues and payable:

Total fee for service

_____ CDHO reg'n# _____

(dental hygienist signature)

Employee/Plan member/Subscriber Information:

Group policy/plan#	Division/section#	Employee/plan member/subscriber name (please print)
Employer		Certificate#/S.I.N.#/ID#
Insurer/agency/plan		Employee/member/subscriber date of birth — day / mo / year

Client Information:

Relationship to employee/plan member/subscriber	Client date of birth (if not self) — day / mo / year	If child: □ student □ disabled Name of school
Are any of the services provided under any other Group Insurance, Dental, WSIB or Government Plan? □ yes □ no		If yes, plan name and #
Is any of the required treatment as the result of an accident? □ yes □ no		If yes, provide details separately

I hereby 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.

_____ signature of employee/plan member/subscriber

_____ date