LIBERTY HEALTH™

Liberty Centre 3500 Steeles Ave. East, Markham, Ontario L3R 0X4
Telephone: (905) 946-4050 OR 1-800-COVER ME® (1-800-268-3763)
Web Site: WWW.COVER-ME.COM
E-mail Address: Call-Centre.mailbox@Health.LMIG.Ca

STANDARD DENTAL CLAIM FORM

PART 1 - DENTIST

UNIQUE NO. | SPEC. | PATIENT'S OFFICE ACCOUNT NO.

PATIENT - LAST NAME | FIRST NAME

ADDRESS | APT.

CITY | PROV. | POSTAL CODE

TELEPHONE NUMBER ( )

DENTIST

TELEPHONE ( )

ASSIGNMENT OF BENEFITS:
I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.

SIGNATURE OF PLAN MEMBER/PATIENT

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 DENTIST 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 PLAN MEMBER/PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION

DATE OF SERVICE			PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES
DAY	MO.	YEAR						

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE. E & OE.

TOTAL FEE SUBMITTED

FOR CARRIER USE

ALLOWED AMOUNT	INC.	%	PATIENT'S SHARE

CHEQUE NO. | DATE

DEDUCTIBLE	PATIENT PAYS	PLAN PAYS

PLAN MEMBER - PLEASE COMPLETE PARTS 2, 3, & 4

PART 2 - PLAN MEMBER INFORMATION

PLAN NO. | IDENTIFICATION NO.

PLAN MEMBER: LAST NAME | GIVEN NAME

ADDRESS (IF DIFFERENT FROM ABOVE) | STREET NO. & NAME | APT. NO.

CITY OR TOWN | PROVINCE | POSTAL CODE

PART 3 - PATIENT INFORMATION

PATIENT RELATIONSHIP:
❑ PLAN MEMBER (0)
❑ SPOUSE (1)
❑ DEPENDANT (2)_____
SPECIFY RELATIONSHIP

PATIENT DATE OF BIRTH _____
(DAY / MONTH / YEAR)

I hereby certify that the information provided herein is true, accurate and complete and I hereby authorize any licensed physician, medical practitioner, hospital, clinic, medical or medically-related facility, provider, insurance company, or any other organization, institute or person which has records of my health (or that of my dependant(s)) to release such information to Liberty Health and I hereby authorize Liberty Health, for underwriting, administrative and claims paying purposes, to exchange any relevant health information regarding myself (or my dependant(s)) with any health professional, institution, insurer or other third party authorized by Liberty Health. A photocopy of this authorization shall be as valid as the original.

SIGNATURE OF PLAN MEMBER/PATIENT | DATE (DAY/MONTH/YEAR)

PART 4 - ADDITIONAL INFORMATION

EMPLOYER NAME _____

HOME PHONE # _____

BUS. PHONE # _____

IS ANY OF THE ABOVE TREATMENT REQUIRED AS A RESULT OF AN ACCIDENT? ❑ YES ❑ NO

IF YES, IS THE WORKPLACE SAFETY AND INSURANCE BOARD INVOLVED? ❑ YES ❑ NO

DO YOU HAVE ANY OTHER DENTAL INSURANCE COVERAGE? ❑ YES ❑ NO

IF YES, INDICATE INSURING COMPANY NAME:

_____

PLAN/POLICY # _____

SPOUSE'S DATE OF BIRTH _____
(DAY / MONTH / YEAR)

SUBMIT CLAIM TO:

LIBERTY HEALTH, LIBERTY CENTRE
3500 STEELES AVE. EAST
MARKHAM, ONTARIO L3R 0X4

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