THE CANADIAN DENTAL HYGIENISTS ASSOCIATION
L'ASSOCIATION CANADIENNE DES HYGIÉNISTES DENTAIRES

Canadian Life & Health Insurance Association
Association canadienne des compagnies d'assurances de personnes

NATIONAL DENTAL HYGIENE CLAIM FORM

PART 1 - REGISTERED DENTAL HYGIENIST	UIN #202 Office # Spec.	Send payment to: ☐ Plan member ☐ Provider If permitted by my plan, I hereby assign my benefits payable from this claim and authorize payment directly to the named Dental Hygienist. x ______________ Signature of Employee/Plan Member/Subscriber
Client Name and Address:	Dental Hygienist Name/Address/Phone Number:	

Date of Service D M Y	CDHA Service Code	INTL Tooth Code	Tooth Surfaces	Description of Services Provided	Dental Hygienist's Fee	Laboratory Charge and/ or Expense	Total Cost
						Total Amount Submitted	

REGISTERED DENTAL HYGIENIST USE ONLY (ADDITIONAL INFORMATION) **Indicate if Preauthorization** ☐

I understand that the fees in this Claim may not be covered by or may exceed my plan benefits. I understand that I am financially responsible for the entire treatment and acknowledge that the total fee shown above is accurate and has been charged to me for services rendered. I authorize release of any additional information required with respect to this claim to my insurance company/plan administrator.

Dental Hygiene services provided are detailed in the Client Record and signed by the client/(parent-guardian) and Registered Dental Hygienist. This is an accurate statement of services performed and the total fee due and payable except for errors and omissions.

I authorize the communication of information related to the coverage of services described in this form to the named Dental Hygienist.

Validated by dental hygienist x ______________ **Validated by client/guardian x** ______________

INSTRUCTIONS FOR CLAIM SUBMISSION

Please ensure Parts 1, 2 and 3 are completed. Then forward the claim form to the appropriate claim office. Information regarding claim form submission may be found in your benefit booklet or from your plan sponsor.

PART 2 - EMPLOYEE / PLAN MEMBER / SUBSCRIBER

1. Group Policy/Plan No. ______________ **Divisions/Section No.** ______________ **Insurer/Administrator** ______________

Employer ______________ Date of Birth

2. Your Details ______________ Certificate/Identification # ______________ Last Name ______________ First Name ______________ Initials ______________ Day / Month / Year

PART 3 - CLIENT / PATIENT INFORMATION

1. IF CLIENT/PATIENT DIFFERENT FROM PERSON CLAIMING:

Client / Patient relationship to person claiming ______________ Date of Birth ______________ Day / Month / Year

If child indicate – Disabled – Yes ☐ No ☐

Student – Yes ☐ No ☐ Client/Patient ID ______________

2. Are Dental Hygiene Benefits or Services provided under any other Group Insurance or Dental Plan, W.C.B., or Government plan? **Yes** ☐ **No** ☐

If so, name of other agency or plan ______________ Policy number ______________

3. Is any treatment required as the result of an accident? Yes ☐ No ☐ **If so, provide details and date of accident on a separate page.**

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

Date ______________ Day / Month / Year

x ______________ Signature of Employee/Plan Member/Subscriber

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL