Dental claim form

Submit via mail: 1403 Kenaston Blvd., Winnipeg MB R3P 2T5
Submit via fax: 204-488-6008
Claim inquiries: 1-866-586-1010 - claims@mystudentplan.ca

This is a: ☐ Claim **or** ☐ Predetermination

The personal information we collect from you is kept in strict confidence and will be used only to assess your claim. Please refer to your benefits card for your Group # and Certificate #.

To be completed by plan member

Plan member information

Name: _____ Date of birth (DD/MMM/YYYY): _____

Email address: _____

Group #: 166175 Certificate #: _____

Pay balance using my Health Care Spending Account (HCSA) if eligible and subject to sufficient HCSA balance? ☐ Yes ☐ No

Note: Please ensure that these expenses have been submitted for reimbursement to all insurance plans under which these expenses may be eligible prior to submitting for reimbursement under your HCSA.

I hereby assign my benefits payable from this claim and authorize payment directly to the named dentist.

_____ _____

Plan member signature Date (DD/MMM/YYYY)

Coordination of benefits

Are you or your dependants entitled to benefits under any other plan? ☐ Yes ☐ No
If yes, please provide the second payor information:

Plan member name: _____ Date of birth (DD/MMM/YYYY): _____

Insurance company: _____

Group #: Certificate #: Coverage effective date: (DD/MMM/YYYY)

_____ _____ _____

Patient information

Name: _____ Date of birth (DD/MMM/YYYY): _____

To be completed by dentist

Name: _____ Phone: _____

Mailing address: _____ Unique number: _____

Date of service Day Month Year	Procedure code	Tooth code	Tooth surface	Dentist fee	Lab charge	Total fee

Is this treatment resulting from: ☐ Accident ☐ Workplace illness or injury

If yes, please provide details including date, location, and what happened: _____

_____

Is this a claim for an initial placement of a: ☐ Denture ☐ Crown ☐ Bridge

If claim is for a replacement, provide initial placement date and reason for replacement: _____

_____

For any additional information or special consideration:

_____ _____

Dentist signature Date (DD/MMM/YYYY)

Authorization

I authorize People Corporation, its advisors and service providers, any healthcare provider, other insurance companies, other organizations, or benefit service providers to exchange information when necessary to assess my claim and administer the group benefit plan. I certify the answers given are true, correct, and complete to the best of my knowledge. If this claim is being made on behalf of my spouse or dependants, I am authorized to disclose information about them, for the purpose of assessing and paying a benefit, if any. I understand that the fees listed in this claim may not be covered or may exceed my insurance benefits. I understand that I am financially responsible for the entire cost of services received and that this claim is for reimbursement of eligible charges.

_____ _____

Plan member signature Date (DD/MMM/YYYY)