HUMANIA ASSURANCE MD®

Dental claim form

For information, please contact us at:
Individual Insurance: Telephone: 450 773-7170 / 514 489-8404 / Toll free: 1 800 773-8404
Group Insurance: Telephone: 450 773-7236 / 514 485-7236 / toll free: 1 800 818-7236
Fax: 450 778-2519 / Email: claims@humania.ca / **Web site:** www.humania.ca
Our address is: 1555, Girouard Street West, Saint-Hyacinthe, Quebec J2S 2Z6

IMPORTANT
1. If possible, please do not submit a claim until incurred expenses total at least $100 or an amount equivalent to the deductible.
2. For covered expenses exceeding $500, please submit an estimate in writing first to verify eligibility of expenses.

Section A – Dentist

Patient

Name _____ Given name(s) _____ Initial _____

Main residence address (n°, street) _____ Apt. _____

City _____ Province _____ Postal code _____ Telephone N° _____

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

Signature of claimant _____ **Date** _____ (YYYY/MM/DD)

Dentist	Unique N°	Spec.	Patient's file N°
	For dentist's use only – for additional information, diagnosis, procedures or special consideration ❑ Duplicate form		
Telephone N°			

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 insurer/plan administrator. I also authorize the communication of information related to the coverage of services described in this form to the named dentist.

Signature of patient, parent or guardian _____ **Date** _____ (YYYY/MM/DD)

Date of service (YYYY/MM/DD) / /	Procedure code	Intl. tooth code	Tooth surface	Dentist's fee	Laboratory charge	Total charges	Section reserved for the administrator
/ /							
/ /							
/ /							

This is an accurate statement of services performed and the total fee due and payable, E & OE.

Total fee submitted _____

IMPORTANT
1. **In the case of major services,** please have your dentist complete the section H (reverse).
2. **In the case of dental accident,** please complete section F (reverse) and have your dentist complete section G (reverse).

Section B – Claimant statement

Policy n° _____ Certificate n° _____ Date of birth _____ (YYYY/MM/DD)

❑ Mr. ❑ Mrs. ❑ Ms. Name _____ Given name(s) _____

Address (n°, street) _____ Apt. _____

City _____ Province _____ Postal code _____ Telephone n° _____ Language ❑ Fr. ❑ En.

Name of the employer (and division if different) _____

Section C – Dependents – To be completed the first time you submit a claim for a dependent child or spouse or whenever there is a change.

Name _____ Given name(s) _____ Date of birth _____

Name _____ Given name(s) _____ Date of birth _____

IMPORTANT
If you are claiming for a dependent child aged 21 or over, who is a full time student at a recognised educational establishment, please forward a proof of registration.

Section D – Coordination of benefits – To be completed if any expenses you are claiming for are covered by another plan.

Claiming instructions: for his/her expenses, your spouse must claim first to his/her insurer. Children's claims must be submitted to the insurer of the parent whose date of birth occurs first in the calendar year. If a claim was already processed by another insurer, please submit a copy of their explanation of benefits and copies of receipts.

Name of your spouse's group insurer	Policy n°	Certificate n°

Coverage: **Health care** ❑ Single ❑ Family **Dental care** ❑ Single ❑ Family

Effective date of coordination of benefits _____ (YYYY/MM/DD)

Cancellation date of coordination of benefits (if applicable) _____ (YYYY/MM/DD)

Please complete the reverse side.

Claimante statement (continued)

Section E – Health & Dental Spending Budget – If you have this coverage, please mark whished options.

If this section is not completed, the claim will be processed according to your basic coverage and no request to modify the option will be accepted. Only medical fees recognised by the Federal tax law are eligible.

❑ **1.** I do not wish to use my Health & Dental Spending Budget.
❑ **2. Ineligible expenses** – I wish to use my Health & Dental Spending Budget to cover expenses that are not reimbursed under my group insurance.
❑ **3. Spouse's family coverage** – I wish to use my Health & Dental Spending Budget for myself and my dependent children to cover expenses that are not reimbursed under my group insurance. I will not submit a claim to my spouse's insurer (coordination of benefits).
❑ **4. Services requiring a medical recommendation** – I wish to use my Health & Dental Spending Budget to cover the expenses related to such services when I do not have a medical recommendation.

Section F – Accident statement – To be completed if the fees submitted are due to an accident.

Date of the accident _____ (YYYY/MM/DD) _____ Place where the accident occurred _____
Circumstances of the accident _____

_____

Date of first treatment _____ (YYYY/MM/DD) _____ Name of the practitioner: _____
Does the patient have an accidental insurance plan? ❑ Yes ❑ No
Has any portion of these expenses been submitted to a government body for reimbursement (WSIB, CSST, SAAQ, …)? ❑ Yes ❑ No

Section G – Dental care subsequent to an accident – To be completed by the dentist.

1. Code Nº of the teeth damaged as a result of the accident _____
2. Condition of the teeth prior to the accident (Were they sound, whole and non vital tooth? Provide details and enclose X-rays). _____

_____

_____

3. If treatment cannot be given immediately, specify the dates and nature of future treatment, as well as the reason for the delay. _____

_____

_____

4. Additional information: _____

I hereby certify that the foregoing statements accurately describe the treatment given and fees incurred, and that said treatment was necessary as a result.

Signature of dentist _____ Speciality (if any) _____ **Date** (YYYY/MM/DD)

Section H – Major treatments – To be completed by the dentist.

Removable prosthesis

Is this an initial placement? ❑ Yes ❑ No
If yes, indicate the extraction date for the replaced teeth. Date _____ (YYYY/MM/DD) _____

In the case of a replacement, please indicate:

A. The date of prior placement: Date _____ (YYYY/MM/DD) _____
B. The reason for replacement: _____

Fixed bridges

Please forward pre-treatment panoramic or bitewing X-rays of left and right side.

If this is an initial placement, please indicate:

A. The extraction date of the replaced tooth/teeth: Date _____ (YYYY/MM/DD) _____
B. The date of prior placement, if a removable partial denture is replaced by the bridge: Date _____ (YYYY/MM/DD) _____
C. Indicate all missing teeth: _____

If this is a replacement, please indicate:

A. The date of prior placement: Date _____ (YYYY/MM/DD) _____
B. The reason for replacement: _____

Crowns, veneers, onlays

Please forward periapical X-rays of the tooth taken prior to the treatment.
Is this the initial placement? ❑ Yes ❑ No
A. The date of prior placement: Date _____ (YYYY/MM/DD) _____
B. The reason for replacement: _____
C. Pertinent details concerning the treatment: _____

_____

Signature of the dentist _____ **Date** _____ (YYYY/MM/DD) _____