AGA BENEFIT SOLUTIONS

STANDARD DENTAL CLAIM FORM

3500 de Maisonneuve Blvd West, Suite 2200, Westmount QC H3Z 3C1

PART 1 : DENTIST

☐ Predetermination

Name	Patient's last name / First name
Address	Address / Apt.
City/Province/Postal code	City
Telephone	Province / Postal code
Licence No.	Telephone

ASSIGNMENT TO THE DENTIST

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

Signature of the subscriber

DATE OF SERVICE Y	M	D	PROCEDURE CODE	INT. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGES	TOTAL CHARGES	RESERVED FOR AGA

This is an accurate statement of services performed and fees charged, except error or omission

TOTAL FEE SUBMITTED ➡ **$**

Dentist's signature : Date :

For dentist use only – Additional information

I understand that the fees listed in this claim may be covered or may be covered only in part. I am financially responsible to my dentist for the entire cost of the treatment.

Signature of patient (or parent or guardian)

SECTION 2 : EMPLOYEE STATEMENT

Insured's name	Group/Division No.	Certificate No.
Address / Apt. / City / Province / Postal code		
Patient's name	Relationship	Date of birth (Y / M / D)

Is this patient covered by another group insurance plan? ☐ YES ☐ NO

If YES, for which coverage(s) : ☐ Health insurance ☐ Individual ☐ Single parent ☐ Dental care ☐ Family ☐ Couple

Policyholder (insured person) : | Date of birth of insured person (Y / M / D) : | Relationship :

Name of insurer : | Contract No. :

Confirmation of student status (for your dependent child of 21 years and over, who is a full-time student). I CONFIRM THAT :

Name of child (for single child only) : | Date of birth (Y / M / D) :

Enter the name of the attended school :

☐ Full-time student ☐ Part-time student ☐ Fall session (September) ☐ Winter session (January)

Is any treatment required as the result of a work accident? ☐ YES ☐ NO

Is any treatment required as the result of a car accident ? ☐ YES ☐ NO

Date and details of the accident. Please provide preoperative X-rays :

Submit expenses not covered to my Health Spending Account or Cost-Plus: ☐ YES ☐ NO

Submit any amount not reimbursed to my Health Spending Account or Cost-Plus: ☐ YES ☐ NO

Is this the initial placement for a denture, crown or a bridge? ☐ YES ☐ NO

If NO, date of prior placement (Y / M / D) :

Type of prothesis replaced : | Reason for replacement :

If YES, date of tooth extraction (Y / M / D) : | If YES, indicate all other missing teeth from the jawbone :

☐ YES, I would like to receive my claims reimbursements directly into my bank account. **You must attach a "VOID" cheque.**

Authorization : I authorize my dentist, any health or dental care providor, any other insurer, the C.S.S.T., the W.C.B. or the S.A.A.Q. to release or exchange information requested by AGA FINANCIAL GROUP INC. (AGA BENEFIT SOLUTIONS) or the insurer and deemed necessary for processing my claim.

Insured's signature : _____ Date (Y / M / D): _____