

Dental claim form

Submit to: 1403 Kenaston Blvd., Winnipeg MB R3P 2T5

Scan and email to: claims.inquiries@siriusbenefits.ca

Inquiries: 1.800.663.8833 **Fax:** 204.488.6008

The personal information we collect from you is kept in strict confidence and will be used only to assess your claim.

Patient details			Dentist unique number				Assignment of benefits	
Name:			Name:				I hereby assign my benefits payable from this claim and authorize payment directly to the named Dentist. EMPLOYEE SIGNATURE: X _____	
Address:			Address:					
City/Province:			City/Province:					
Postal Code:			Postal Code:		Phone:			
DATE OF SERVICE	PROCEDURE CODE		TOOTH CODE	TOOTH SURFACE	DENTIST FEE	LAB CHARGE	TOTAL FEE	
DAY	MONTH	YEAR						
Insurance info: Employee Name: _____ Birthdate: _____ Gender: _____ Employer: _____ GROUP #: _____ CERT#: _____ Relationship to Patient: _____ Patient Birthdate: _____					Dentist use only: 1. Treatment resulting from: <input type="checkbox"/> Accident <input type="checkbox"/> Workplace illness or injury Details: _____ 2. Treatment involving: <input type="checkbox"/> Denture <input type="checkbox"/> Crown <input type="checkbox"/> Bridge Initial Placement Date & Reason for Replacement: _____ 3. Additional Information or Special Consideration: <div style="border: 1px solid black; height: 50px; width: 100%; margin-top: 5px;"></div>			
Co-insurance/Second payor info: Name of Family Member Insured: _____ Birthdate: _____ Gender: _____ Relationship to Patient: _____ Name of Company: _____ GROUP #: _____ CERT#: _____					This is an accurate statement of services performed and the total fee due and payable, errors and omissions accepted. Dentist signature: X _____			
Authorization: I authorize Sirius Benefits, 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 dependents, 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. Employee signature: X _____								