KECHNIE BENEFITS

Dental Plan Claim Form

CANADIAN DENTAL ASSOCIATION / L'ASSOCIATION DENTAIRE CANADIENNE

PART 1 - DENTIST

Patient's Full Name

Address Apt.

City Province Postal Code

Dentist

Phone #:

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

Signature of Subscriber

For Dentist's use only - For Additional Information, Diagnosis, Procedures, or Special Consideration

Duplicate Form ☐

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 service rendered.
I authorize release of the information contained in this claim form to my insuring company/plan administrator.

Signature of Patient (Parent/Guardian)

Date of Service	Procedure Code	Intl. Tooth Code	Tooth Surfaces	Dentist's Fee	Laboratory Charge	Total Charges

This is an accurate statement of services performed and the total fee due and payable.

TOTAL FEE SUBMITTED

** IMPORTANT INFORMATION **

Pre-Treatment Plan: If your Dentist has recommended crowns and/or bridge work, or any other dental expense over $500 (per patient), please have your dentist complete a Pre-Treatment plan and submit it to Kechnie Benefits before treatment begins.

Co-Ordination of Benefits: A method used by the insurance industry to determine the order of paying benefits when the spouse and children are covered under more than one plan. For example, a spouse who is covered under his/her employer's plan must submit to that employer's plan first, and claims for children must be submitted under the plan of the parent with the earlier month then day of birth in the calendar year.

Mailing Instructions: Mail your completed form to:

Kechnie Benefits
447 Frederick St., 4th Floor, Kitchener, ON N2H 2P4

PART 2 - PLAN MEMBER INFORMATION

Member ID _____ Policy/Plan #: _____ Address: _____

Name of Employer _____

Plan Member's Name _____

Date of Birth: _____ (Day Month Year) Sex: M F Section: _____ Phone #: (_____) _____

PART 3 - PATIENT INFORMATION

1) Relationship to Plan Member: SELF SPOUSE CHILD

Date of Birth: _____ (Day Month Year)

Children Only - check if: Full Time University/College ☐ Disabled ☐

2) Is this a replacement of a crown, bridge, or denture? No Yes

If yes, date of previous replacement: _____ (Day Month Year)

3) Is treatment required for orthodontic purposes? No Yes

PART 4 - CO-ORDINATION OF BENEFIT AND ACCIDENT INFORMATION

1) Are any of the expenses covered by another group plan? No Yes
If yes, complete the following information about the person who is the MEMBER UNDER THE OTHER PLAN:

Other Member's Name: _____

Certificate/ID #: _____

Date of Birth: _____ (Day Month Year)

Insurance Company Name: _____

Policy/Plan #: _____

2) If your dental coverage under another group insurance plan has been cancelled, please give the cancellation date: _____ (Day Month Year)

3) Is any treatment required as a result of an Accidental Injury? No Yes

If yes, did the accident happen at work? No Yes

Please provide a letter: 1) Explaining the details of the accidental injury, and 2) Indicating if another party is liable

Date of Accidental Injury: _____ (Day Month Year)

PART 5 - AUTHORIZATION

I certify that the information given on this form is true, correft and complete to the best of my knowledge. I authorize the release, by any health care provider, Kechnie Benefits or any of its agents, of any information necessary for the administration of this claim or my group plan. This may include the release of information to pharmacies, physicians, or dentists to promote the safe and effective use of drugs. A photostat of this authorization is as valid as the original.

Plan Member's Signature X _____

Date: _____ (Day Month Year)