DENTAL PRE-TREATMENT FORM

			Unique No.	Spec	Patient's Office Acct No
PATIENT	Patient Last Name	Given Name	DENTIST		
	Address	Apt			
	City	Province / Postal Code	Phone No		Signature of Dentist

Tooth #	Procedure Code		
		$	+L
		$	+L
		$	+L
		$	+L
		$	+L
		$	+L
		$	+L
		$	+L

Total $ +L

Comments:

Additional Comments:

Use this space to provide additional information or expertise statement pertinent to the treatment plan.

#'s _____ Endodontically Treated
#'s _____ Incisal/Cuspal Fracture
#'s _____ Legible X-rays Enclosed
#'s _____ Unrestorable with Conventional Materials
#'s _____ replacement of unserviceable existing Crown / Bridge

If duplicate x-rays, indicate right or left.

This is an approximation only.

Final laboratory charges will be included on claim form.

By signing this claim form and/or submitting actual receipts, I agree that the information provided on this form is complete and accurate. I understand that the information provided by me to Green Shield Canada about myself and my dependants, will be used by Green Shield Canada for claims adjudication and any other services necessary in the administration of our benefits which may include the exchange of information with other parties to administer this benefit claim.

I am authorized by my spouse and/or dependants to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder.

All claims must be submitted within 12 months of the date of service (unless otherwise stated in your benefit plan documentation).

For Predetermination of Benefits, mail to:

GREEN SHIELD CANADA
P.O. BOX 1608
WINDSOR, ONTARIO
N9A 7G1

Attention: Dental Department
(519) 739-1133 or
CUSTOMER SERVICE CENTRE 1-888-711-1119

This section to be completed by patient:

PATIENT _____
NAME _____
ADDRESS _____
CITY, PROVINCE _____
POSTAL CODE _____

Green Shield Identification Number

I authorize the release of the information outlined in this treatment form to my insuring company or its agents.

_____
Signature of Patient (or Guardian/Parent)