



Limited to Endodontics

Endodontics and Endodontic Surgery
Est. 1981

Electronic Dental Claims Submissions Patient Information/Consent Form

In the past, our computer has printed an Insurance Claim Form for you. It has been your responsibility to complete and sign the form and mail it to your insurance company for processing. After a few weeks, you receive a cheque from your insurance company in the mail, along with a statement called the "Explanation of Benefits" (EOB) which explains the portion of the claim that is covered in your dental plan.

As a participant in Electronic Claims Submission, your experience will be slightly different. Your insurance claim form will be sent automatically to your carrier by our computer, therefore you will not receive a paper claim. In its place, you will receive one of two forms:

You may receive a "Claim Acknowledgement" form which comes directly from the insurance carrier. This form verifies that your dental claim has been received by them for processing. The second form applies to claims processors who can actually process your claim instantaneously, in which case you will receive an "Explanation of Benefits" form which indicates the exact amount of the claim for which you will be reimbursed.

Electronic Claims Submission saves you the effort and cost of mailing the insurance from yourself - we provide this service for you. As well, your claims processor will be able to process your claim faster, which means that you will receive your cheque in a more timely fashion than before. Unfortunately, not all insurance companies are currently accepting claims submitted electronically. Some will likely be joining the system in future. In order to submit claims electronically, we require insurance information that you may not have on file. Please complete this form and return it to us as soon as possible. Thank you.

Name of Patient: _____ Date of Birth: _____

Name of Policy Holder: _____ Date of Birth: _____

Insurance Company: _____ Policy No.: _____

Certificate or Subscriber I.D. No.: _____ S.I.N.: _____

Suffix/Division No.: _____ Group No.: _____

Place of Employment: _____ Phone No: _____

Relationship of patient to policy holder: Dependent: _____ Spouse: _____

I authorize release, to my dental benefits plan administrator, information contained in electronically submitted claims.

Signature of patient, parent, or guardian

Date

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