nexgenRx

Questions about your coverage?
416-695-1799 or toll-free 1-866-424-0257

Used Car Dealers Association UCDA MEMBERS ONLY HEALTH PLAN

DENTAL CLAIM FORM

PART 1 - TO BE COMPLETED BY DENTIST

PATIENT

LAST NAME | FIRST | UNIQUE NO. | SPEC. | PATIENT'S NO.

ADDRESS

CITY | PROV. | POSTAL

DENTIST

PHONE

FOR DENTIST'S USE ONLY - ADDITIONAL INFO, DIAGNOSIS, PROCEDURES OR SPECIAL CONSIDERATION

☐ **THIS IS A DUPLICATE FORM**

ASSIGNMENT - I hereby assign my benefits payable as a result of this claim to the above named dentist and authorize payment directly to him/her.

SIGNATURE OF PATIENT

SIGNATURE OF PARENT/GUARDIAN

DENTAL OFFICE VERIFICATION BY:

SERVICE DATE DD MM YEAR	PROCEDURE CODE	TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LAB CHARGE	TOTAL CHARGE

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE.

TOTAL FEE SUBMITTED: $

☐ TREATMENT PLAN

WHEN A PROPOSED COST OF TREATMENT EXCEEDS $600.00, A TREATMENT PLAN MUST BE FILED WITH NEXGENRX. YOU WILL BE ADVISED OF THE BENEFITS PAYABLE UNDER YOUR PLAN BEFORE TREATMENT BEGINS. PRE-TREATMENT X-RAYS ARE REQUIRED FOR SOME PROCEDURES.

MAILING INSTRUCTIONS - *mail completed form in envelope to:*

NexGenRx Inc. 145 The West Mall, 110 U Toronto, Ontario M8Z 5M4

PART 2 - TO BE COMPLETED BY EMPLOYEE/PLAN MEMBER

CONTRACT NO. _____

EMPLOYER _____

MEMBER NAME (PRINT) _____

CERTIFICATE NUMBER _____

PART 3 - PATIENT INFORMATION

1. PATIENT RELATIONSHIP TO PLAN MEMBER: _____

DATE OF BIRTH (DD/MM/YYYY): _____

IF CHILD INDICATE: ☐ STUDENT ☐ DISABLED

IF STUDENT, INDICATE SCHOOL: _____

2. DO YOU HAVE DENTAL BENEFITS UNDER ANY OTHER GROUP INSURANCE PLAN, W.C.B., OR GOV'T PLAN?

☐ YES ☐ NO INSURER NAME: _____

CONTRACT NO. _____

SPOUSE'S BIRTHDATE: _____

3. IS ANY TREATMENT REQUIRED AS A RESULT OF AN ACCIDENT? IF YES, GIVE DATE AND DETAILS. ☐ YES ☐ NO

4. IF DENTURE, CROWN, OR BRIDGE, IS THIS INITIAL PLACEMENT? IF YES, GIVE DATE AND DETAILS. ☐ YES ☐ NO

5. IS THIS AN ORTHODONTIC CLAIM? ☐ YES ☐ NO

6. I certify that the info given above is true and complete and that I have the right to disclose personal information of my spouse and dependents (if any) in connection with any claim made by me. I authorize any person having and personal information relevant to such claim, including the above-named dentist, NexGenRx, any insurer, administrator of any publicly or privately funded benefit plan or program, or claims auditor, to exchange any such personal information in connection with assessing any such claim and/or administering my benefit plan.

_____ _____

Signature of plan member **Date** (DD/MM/YYYY)