CDCS HEALTH CLAIMS INC.

1556 Lasalle Side Unit 3, Sudbury, ON P3A 1Z7
705-675-2222 800-265-2327 Fax 705-675-2376

CDCS Cover Card Call 1-800-265-2327

PART 1 – DENTIST

Enter Pre-Determination number here if available:

Unique No. | Spec. | Patients Account No.

Last Name | First Name

Address | Apt.

City | Province | Postal code

DENTIST

Date of Service Day	Mo.	Yr.	Procedure Code	INTL Tooth Code	Tooth Surface	Dentist's Fees	Laboratory Charges	Extra Expenses	Total Charges
TOTALS									

Dentist Signature

Day/Month/Year

This is an accurate statement of the services performed and the fees charged. E & OE.

For dentist's use only. Additional information Re: Diagnosis, Procedures, or Complications, and Special Considerations.

I understand that the fees listed in this claim may not be covered by or may exceed my policy benefits.
I understand that I am financially responsible to my dentist for the entire cost of this treatment.
I authorize release of the information contained in this claim form and the communication of information related to the coverage of services described in this form to my insuring company, plan administrator and to the named dentist.

☐ Signature of Patient or Guardian

ASSIGNMENT ONLY

I hereby assign benefits payable from this claim directly to the above name dentist.

Signature of Employee/Cardholder

PART 2 – EMPLOYEE/CARDHOLDER

Policy Number/Group Number:

Name of Employer/Policyholder

Employee Certificate Number:

Name of Employee/Cardholder

If student is overage enter School Name and Expected Graduation date:

Spouse ____ Dependent ____ Other (specify) ____

Patient relationship and Date of Birth of Patient (d/m/y)

Is any treatment for orthodontic purposes? Yes ☐ No ☐

Are dental benefits payable for this claim insured by any other group insurance plan? If yes, indicate name of insurer and their policy number. Yes ☐ No ☐ Spouse's date of Birth (d/m/y) ____

If any of the above treatment is required as the result of an accident indicate date of accident and details. (d/m/y)

If denture, crown, or bridge, is this the initial placement? Yes ☐ No ☐
If No, please give date of prior placement, or age and reason for replacement.
If yes, please indicate details with dates if applicable:

I hereby certify that the information give by me is true, correct, and complete to the best of my knowledge.

☐ Signature of Employee/Cardholder | Day/Month/Year

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL