Premier Health

DENTAL CLAIM FORM

Claim No.____________________

PROOF OF CLAIM MUST BE SUBMITTED WITHIN 90 DAYS OF FIRST DAY OF ACCIDENT OR ILLNESS.

Please submit completed form via Email to Medical_Claims_TT@cgcoralisle.com or via Fax to 441 295 9036.

PART 1 To be completed by the EMPLOYEE/INSURED (please print)

Full Name of Insured ____________________

Effective and/or Termination Date (DD/MM/YY) ____________________

Group Policy No. ____________________ Certificate No. ____________________

Employer Name ____________________ Dental Plan ☐ Basic ☐ Comprehensive

Employer's Mailing Address ____________________ Tel. No. ____________________

Full Name of Patient ____________________

Patient's Mailing Address ____________________ Tel. No. ____________________

Patient's Date of Birth (DD/MM/YY) ____________________ Patient's Gender ☐ Male ☐ Female

Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other ____________________

If the patient has other Dental Insurance coverage, provide name of policy holder and policy number____________________

DECLARATION:

I hereby certify that the foregoing answers are true and correct to the best of my knowledge and hereby authorize all doctors, or other persons who treated me, and all hospitals or other institutions, to furnish full information including full copies of records regarding this claim to The Beacon Insurance Company Limited.

Patient's or Authorised Person's Signature ____________________ Date ____________________

I hereby authorise payment of the Insurance Benefit directly to the Dentist named below for amounts otherwise payable to me.

Patient's or Authorised Person's Signature ____________________ Date ____________________

PART 2 To be completed by the ATTENDING DENTIST (please print)

Name of Dentist ____________________

Address of Dentist ____________________

Dentist Society or T.I.N. (if applicable) ____________________ Dentist Licence No. (if applicable) ____________________

Specialist in ☐ Orthodontics ☐ Endodontics ☐ Oral Surgery ☐ Periodontics ☐ Other ____________________

Date of first visit in this current series (DD/MM/YY) __________ Dentist Tel. No. ____________________

TREATMENT DETAILS

1. Please check if treatment is a result of ☐ occupational illness ☐ injury ☐ motor accident ☐ other accident __________
2. Are any services covered by another plan? ☐ Yes ☐ No Details ____________________
3. Are radiographs or models enclosed? ☐ Yes ☐ No Details ____________________
4. If Prosthesis, is this the initial replacement? ☐ Yes ☐ No If No, give date of prior replacement (DD/MM/YY) __________
5. Is this treatment for orthodontics? ☐ Yes ☐ No If Yes, date service commenced (DD/MM/YY) __________

   Date appliances placed (DD/MM/YY) ____________________ Months of treatment remaining ____________________
6. Please tick and fill in amount: ☐ Statement of ACTUAL charges or ☐ Pre-treatment ESTIMATE of charges = __________

Beacon

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NOTES:

1. Examination Details to be completed on chart below.
2. Identify missing teeth with “X” on dental plan to right.
3. If services cannot be completed within 90 days from date of examination, patient must obtain a new authorisation and claim form for uncompleted services.
4. A pre-operative and post-operative x-ray of root canal work is required. Post-operative bite-wing x-rays must be provided when requested by The Beacon Insurance Company Limited.

PART 3 EXAMINATION AND TREATMENT PLAN

List in order from tooth no. 1 through no. 32, using chart system shown

TOOTH No. OR LETTER	SURFACE	DESCRIPTION OF SERVICE (Include x-rays, prophylaxis, materials used, etc.)	DATE OF SERVICE (DD/MM/YY)	PROCEDURE NUMBER	FEE	OFFICE USE ONLY
				TOTAL FEE CHARGED		

MAXIMUM ALLOWABLE ____________

DEDUCTIBLE ____________

BALANCE ____________

CO-INSURANCE ____________

CARRIER PAYS* ____________

*Covered expenses on “Carrier Pays” are authorised. Payment will be made provided the treatment is performed while the patient is covered as per “Effective and/or Termination Date”. Payment will be subject to all limitations and maximums.

PART 4 DENTIST’S CERTIFICATION FOR SERVICES PROVIDED

I have been paid. ☐ Yes ☐ No I certify the above items (no. of items______) were provided and completed by me.

Signature____ Date ____________________

PART 5 DECLARATION (To be signed by the Patient AFTER all the work is complete.)

I hereby certify that the procedures as indicated by “Date of Service” have been completed to my satisfaction.

Patient’s Signature ____ Date ____________________

The Beacon Insurance Company Limited 13 Stanmore Avenue, P.O. Box 837, Port of Spain 190211, Trinidad & Tobago
Tel 868 225 1256 | medical_claims_tt@cgcoralisle.com | beacon.co.tt

Underwritten and administered by Coralisle Medical Insurance Company Ltd.
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A member of Coralisle Group Ltd.

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