PO Box 1671, Windsor, Ontario N9A 0C6
Attn: Dental Department or CUSTOMER SERVICE CENTRE 1-888-711- 1119

NOVA SCOTIA GOVERNMENT DENTAL CLAIM FORM

PART 1 - PROVIDER

Unique No | Spec | Patient's Office Account No.

I hereby assign my benefits payable from this claim to the named provider and authorize payment directly to him/her.

Signature of Patient / Guardian

PATIENT
Patient Last Name   Given Name
Address   Apt.
City   Province   Postal Code

PROVIDER
Phone No

For provider's use only – please check applicable location of service and include program name. Include additional information if necessary.

- ☐ Hospital visit
- ☐ Office visit
- ☐ Program name ______________________________

I understand that the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to my provider for the entire treatment. I acknowledge that the total fee of $ _________ is accurate and has been charged to me for services rendered. I authorize release of the information contained in this claim form to my insuring company/plan administrator.

I also authorize the communication of information related to the coverage of services described in this form to the named provider.

Signature of Patient (Parent/Guardian) ______________________________

Office Verification

Date of Service DAY MO YR	Procedure Code	Int'l Tooth Code	Tooth Surfaces	Provider's Fee	Laboratory Charge	Total Charges	Allowed Amount	Code

This is an accurate statement of services performed and the total fee due and payable, E & OE.

TOTAL FEE SUBMITTED

INSTRUCTIONS FOR CLAIM SUBMISSION

Please carefully fill in all pertinent areas and sign the completed claim form. Refer to MSI Card for correct patient information. Incomplete or incorrect claim forms will be returned or rejected and will result in a delay in reimbursement.

PART 2 - PARENT/LEGAL GUARDIAN INFORMATION

All claims must be received within 6 months of the date of service

Parent / Legal Guardian Name (Please Print)

Last Name   Given Names

Parent/Legal Guardian information must be complete for dependent children.

PART 3 - PATIENT INFORMATION

Patient's Name (Please Print)

Last Name   Given Names

MSI Number of Patient
- 00

Patient's Date of Birth
Yr | Mo | Day

1. Patient: Relationship to Plan Member ______________________
   If child indicate: Student ☐ Handicapped ☐
   If student, indicate school______________________
2. Are any dental benefits or services provided under any other group insurance or dental plan, W.S.I.B. or Government Plan?
   No ☐ Yes ☐

   If Yes, Policy No. _________________ Spouse Date of Birth ___________

   Name of other Insuring Agency or Plan ______________________________
3. Is any treatment required as the result of an accident? If Yes, give date and details separately. No ☐ Yes ☐
4. If denture, crown or bridge, is this initial placement? Give date of prior placement and reason for replacement. No ☐ Yes ☐
5. Is any treatment required for orthodontic purposes? No ☐ Yes ☐

All information recorded on this form is confidential.

I authorize the release of any information or records required in respect of this claim to insurer/plan administrator and certify that the information given is true, correct and complete to the best of my knowledge.

______________________________ Date ______________________
Signature of Patient / Guardian   Day Month Year

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 dependents, 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 dependents to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder.