54 Rushworth St., San Fernando
Tel: 657-3812 / Fax: 653-4850

1st Floor, King's Court
44 Park St., Port of Spain
Tel: 627-0473
email: claims@mediservinternational.com

# DENTAL CLAIM FORM

## PRINCIPAL'S STATEMENT

(Note: ALL questions MUST be answered for every claim.
NA = Not Applicable)

Principal's RAN: _____ Plan Code: _____ Group Name: _____ Group Number: _____

Patient's Present Coverage $_____Original Commencement Date _____Up/Downgrade Date_____ Claim No_____

1. Principal's Name_____ Date of Birth: _____ Sex: Female ☐ Male ☐
2. Name of Patient_____ Date of Birth: _____ Sex: Female ☐ Male ☐
3. Relationship of Patient to Principal: Self ☐ Spouse ☐ Child ☐ Other ☐ (Explain) _____
4. Name of Illness or Condition _____ Attending Physician _____
5. Has the claimant familiarized him/herself with the terms and conditions of the contract for this medical plan? Yes ☐ No. ☐
6. When did symptoms of this illness first occur? ⇒ ⇒ ⇒ ⇒ D /M /Y. NA ☐
7. Was treatment necessary because the patient was injured or poisoned? ⇒ ⇒ Yes.☐ No ☐
8. If patient was injured or poisoned, state the **Date**, **Time** and **How** the incident occurred. _____ NA ☐
9. Did patient voluntarily participate in an activity that targeted the patient for abuse or endangerment? ⇒ Yes. ☐ No ☐
10. Is patient entitled to Workmen Compensation or coverage under any other medical plan? ⇒ ⇒ Yes. ☐ No ☐
11. If you gave 'Yes' to question 10 above, give name of Company. _____ NA ☐
12. If you gave 'Yes' to question 10 above, has patient made any claim for the relevant benefits? ⇒ Yes. ☐ No. ☐ NA ☐
13. GEMS credit consumed? $_____ D /M /Y. Repaid? $_____ D /M /Y. Balance Unpaid? $_____ NA ☐
14. Check all your receipts submitted for this claim and in the spaces provided below please write your total expenses for each category.

A) Examination? $_____ D) X Ray? $_____ G) _____? $_____ J) Discount
B) Cleaning & Polishing? $_____ E) Filling? $_____ H) _____? $_____ (If Applicable)
C) Root Canal? $_____ F) Crown? $_____ I) _____? $_____ $_____
D) What is the discounted value of the expenses supporting your claim for which you have submitted the receipts listed above? $_____

I hereby certify that the forgoing 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 their records) regarding this claim to MEDISERV INTERNATIONAL Ltd. or its assigns (the Company). I also understand that only original documents are valid in support of my claim and that once submitted, all documents associated with the expense and other relevant circumstances associated with the loss, becomes the property of the Company.

Date_____ Principal's Signature X_____ Patient's Signature (if over 18yrs) X_____

**APPLICATION FOR ASSIGNMENT OF COVERAGE BENEFITS** **NA** ☐

I hereby authorize MEDISERV INTERNATIONAL Ltd. to pay to _____ whatever benefits to which I may be entitled with respect to the services rendered to the named patient from _____ 20____ to _____ 20____
All Charges that are not covered by the Medical Plan shall be borne by me.

_____ X_____ **NA.** ☐
Date Principal's Signature

FOR OFFICIAL USE ONLY

_____ _____ X_____ _____
Date Received Recipient's Name (PRINT) Group Administrator's Signature Title

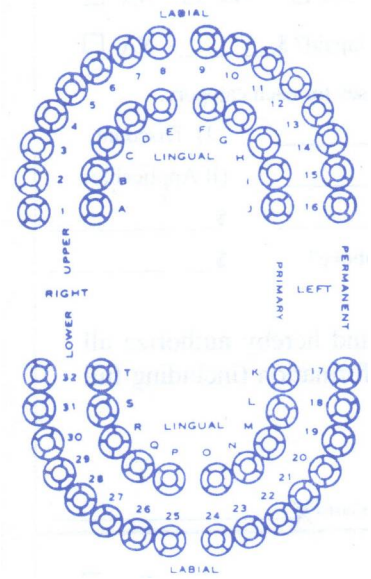
# ATTENDING DENTIST'S STATEMENT

PLEASE COMPLETE THIS FORM AND GIVE TO YOUR PATIENT WITH A RECEIPT

1. Principal's Name:_____ Principal's Registered Account No. (RAN) : _____
2. Address: _____
3. Patient's Name: (If not Principal): _____

   A) Relationship To Principal: _____ B) Date of Birth: D_____M_____Y_____
4. Employer's Name: _____
5. Dentist' s Name (PRINT): _____
6. Address: _____
7. Is any of the treatments for:- A) Orthodontic Purposes Yes ☐ No ☐ B) Accidental Injury? Yes ☐ No ☐
   C) Occupational Injury? Yes ☐ No ☐
8. If Prosthesis, is the initial placement Yes ☐ No ☐

   Reason for replacement: _____
9. Date of prior replacement: D_____M_____Y_____
10. Are X-Rays enclosed? Yes ☐ No ☐ If Yes, How many? _____




| EXAMINATION AND TREATMENT RECORD – USE CHARTING SYSTEM SHOWN | | | | | | | I hereby certify that services have been performed **Dentist's Signature** |
|---|---|---|---|---|---|---|---|
| Tooth No. or Letter | Surfaces | Description of service including X-Rays, Prophylaxis materials used, etc. | Date Services Performed | | | Fee | |
| | | | **D** | **M** | **Y** | | |
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| Orthodontics: (Give diagnosis, class of malocclusion and describe appliance(s) in above treatment section) | | | | | TOTAL | | |

INDICATE MISSING TEETH WITH AN "X"

DATE FIRST APPLIANCE INSERTED D_____ M_____Y_____ DATE LAST APPLIANCE REMOVED D_____M_____Y_____

TREATMENT PERIOD (number of months) _____ TOTAL FEE: $ _____