Dental Claim Form

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quikcard.com

Or e-mail the completed form with a copy of your receipt to: claims@quikcard.com

Provider Information

Provider ID#: ______________________

Name: ______________________

Address: ______________________

City: ______________________

Province: __________ Postal Code: ______________

Telephone: ______________________

Sign Here ______________________ ______________
Signature of Provider or Office Designate Date

Patient Information

Last Name: ______________________

Given Names: ______________________

Address: ______________________

City: ______________________

Province: ______________________

Postal Code: ______________________

Please Make Payment to

Provider Cardholder

Date of Service D	M	Y	Procedure Code	Tooth Code	Tooth Surfaces	Dentist/Lab Fee	Total Charge
						Total Charge	

Patient's Date of Birth

______ Day ______ Month ______ Year

Full Name of Cardholder

____

____

Patients Relationship to Cardholder

____

Cardholder Number

____

Group Number

____

Employer Name

____

Is this Dental Treatment covered by any other Dental Plan? ❑ Yes ❑ No

If yes, name of Insurer

____

Statement & Authorization

CLAIMANT'S STATEMENT: I declare that the above statements are true and complete to the best of my knowledge and belief. I am authorized to provide and receive the personal information of my spouse and dependants to submit this claim and for benefit administration purposes and to give the authorization set out below on my own and any of their behalf.

PRIVACY NOTICE: The information requested in respect of this claim is required by Quikcard for benefit administration purposes. For these purposes Quikcard will, where necessary, collect from and exchange information with others. For more information consult Quikcard's privacy policy at www.Quikcard/privacy-policy.php or contact Quikcard by phone or mail.

QUIKCARD™

Confirmation Number

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AUTHORIZATION: I authorize for a period of not less than twelve and not more than twenty-four months from the date hereof, any employer, physician, practitioner, health care provider, hospital, health care institution, and any other medical or medically related facility, any insurance company, workers compensation board or similar plan or organization, federal, territorial or provincial government department, or any other corporation or organization, institution or association, to release and exchange with Quikcard, all personal health information or any other information or records in its possession that is requested while and for the purpose of administering this claim. A photocopy of this authorization shall be as valid as the original.

COSMETIC SERVICES: I declare that the health services claimed on this form are medically required and not of a cosmetic nature.

❑ **Yes** ❑ **No** (A box must be checked in order for your claim to be processed.)

Sign Here ______________________ ______________
Signature of Cardholder Date