SEAFARER'S MEDICAL PLAN
1333 ST. JACQUES
MONTREAL QC H3C 4K2
TEL: (514) 931-7859
FAX: (514) 931-3667



STANDARD DENTAL CLAIM FORM



Canadian Dental Association																										
PA	PART 1 - DENTIST UNIQUE NO. S														NO.	SF	PEC	. PA	TIEN	VTS	OF	FICE	AC	COUNT NO.	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECT- LY TO HIM/HER.	
Р	LAST NAME GIVEN NAME										T	NAME														
ATI	ADDF	ESS											DE N	ADDRESS												
Ė	CITY		PROV. POSTAL CODE									STT	TELEPHONE													
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	FOR DENTIST'S USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, CONSIDERATION.												3, PROCEDURES, OR SPECIAL								OR MAY EXCEED MY P				THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY PLAN BENEFITS. I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE	
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																SIGNATURE OF SEAFARER OR SPOUSE										
DUP	OFFICE VE															ERIFICATION	N / DENTIST'S SIGNATURE									
-	DATE OF INTL.																									
	MO.		PF	CO	DE	Æ		OTH	TOOTH SURFACES			FEE	STS			CHARGE			Т	ОТА	L CI	HAR	RGE	S	FOR SEAFARERS' MEDICAL PLAN USE	
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THIS IS AN ACCURATE STATEMENT OF SER- VICES PERFORMED AND THE TOTAL FEE DUE TOTAL FEE SUBMITTED																										
AND	PAYAE	LE, E	& OE			-	-	_						בט	_		-									
INSTRUCTIONS FOR CLAIM SUBMISSION 1. HAVE THE ATTENDING DENTIST COMPLETE PART 1. 3. COMPLETE A BLUE CLAIM FORM (STATEMENT BY THE SEAFARER).																										
2.	СОМР	LETE	PAF	RTS	2 AN	1D 3	BELC	ow.											4.	F	RET	URI	N B	OTH FORM	AS TO THE SEAFARERS' MEDICAL PLAN.	
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NAME OF SEAFARER:UNION N°SOCIAL INSURANCE N°																										
									TION																	
1.	PATIE	NT :										_					_				IF THE TREATMENT INVOLVES THE PLACEMENT OF A DENTURE: A) IS THIS THE INITIAL PLACEMENT?					
2.	IF CL/	AIM IS							, IS THAT C			_		- "	EAI	н			_		UPPER YES NO					
	PERM			/ DIS	SABL	LED	?		YES NO												.ow				s NO 🗆	
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4.		Y OF					RK F	OR OF	RTHODONTI	IC P	URF	208	ES	1					7.	F N	REQ	UES	STE L F	D IN RESI	ELEASE OF ANY INFORMATION OR RECORDS PECT OF THIS CLAIM TO THE SEAFARERS' INISTRATOR AND CERTIFY THAT THE INFORMATION RECT AND COMPLETE TO THE BEST OF MY	
5.	•	ANY T				_	EQUIF	RED A	AS THE RES	ULT	OF	AN	I AC	CIDI	EN	T?				K	KNOWLEDGE. SIGNATURE OF SEAFARER OR SPOUSE:					
	GIVE	DATE	ANI) DE	TAII	LS _				_	_	_	_		_				_	-						
		CLAIR						VORK	KERS' COMP	EN	SAT	ION	BE	NEF	ITS	3?								DATE: DA	AY MONTH YEAR	