QUIKCARD™

Innovative Benefits Solutions

Dental Claim Form

Head Office
200 Quikcard Centre **p 780.426.7526**
17010 103 Avenue **f 780.424.7669**
Edmonton AB T5S 1K7 **1.800.232.1997**

Atlantic Canada
201 1600 Bedford Highway **p 902.492.2111**
Bedford, NS B4A 1E8 **f 902.492.2112**
1.888.846.4484
quikcard.com

Provider Information

Provider ID# _____

Name _____

Address _____ City _____

Province _____ Postal Code _____

Telephone _____

Provider Signature _____

Patient Information

Last Name _____

Given Names _____

Address _____

City _____

Province _____

Postal Code _____

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

Please Make Payment to

❑ Provider ❑ Cardholder

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

_____

I declare that the above statements are true and complete to the best of my knowledge and belief. I understand that fees submitted may be ineligible or exceed plan limits and may not be reimbursed. I agree that I am financially responsible to my provider for his or her fees I authorize Quikcard to collect from and exchange information with 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, information for benefit administration purposes.

_____ _____

Signature of Patient or Parent/Guardian Date

QUIKCARD™

Confirmation Number

_____

For more information consult Quikcard's privacy policy at www.quikcard.com/privacy-policy/ or contact Quikcard by phone or mail.