Quikcard

V2023112920

CLAIM FORM – For Dental

INSTRUCTIONS: Attach detailed receipts for all expenses, sign, and date form.	**IMPORTANT:** This claim form will be returned if incomplete or unsigned.	**COMPLETED FORM:** Can be mailed, faxed, or emailed to claims@quikcard.com.

Please make payment to: ☐ Provider ☐ Cardholder

1. Cardholder Information

Name | Group # | Certificate # | Date of Birth D/M/Y

Address | City | Province | Postal Code

2. Patient Information *(if not the cardholder)*

Name | Date of Birth D/M/Y | ☐ Spouse | ☐ Dependent

3a. Provider Information

Name

3b. Required only if the payment is to the Provider*

Address | City | Province | Postal Code

Signature of Office Designate | Date | Quikcard Confirmation # | Unique #

*Must be registered to received payment directly from Quikcard. Visit www.quikcard.com for more information.

4. Coordination of Benefits

Was this treatment covered by any other plan? ☐ Yes ☐ No

If yes, name of the other insurer

***Please provide a copy of their payment statement**

5. Claim Details *(Please keep a copy of this form and receipts for your records)*

Date of Service	Procedure Code	Tooth Code	Tooth Surfaces	Dentist Fee	Lab Charges	Total Charge

If additional space is needed, attach a separate page to this claim form

Credit card receipts and or debit slips alone are insufficient. All receipts must include:

- Patient name
- Date of Service
- Name of treatment provided with dental procedure codes for all applicable. (Example: tooth code for extractions and tooth code and surfaces for fillings)
- Charge for each service
- Provider's name and professional designation

6. Disclaimers

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

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.

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

PRODUCTS OR SERVICES RECEIVED: I declare that the products or services listed on this claim have been received in full.

CLAIMANT'S STATEMENT: I declare that the information contained on this claim form is 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 benefits administration purposes and to give the authorization set out below on my own and any of their behalf.

Signature of Cardholder _____ Date _____