AVANTAGES SOCIAUX
MÉDIC CONSTRUCTION

CLAIM
FOR DENTAL EXPENSES

1. SUPPLIER

Unique no.	Spec.	Patient file no.

PATIENT

Last name _____ First name _____

Address _____ Apt. _____ City _____ Province _____ Postal code _____

Is this a new address? ☐ Yes ☐ No

DENTIST

Telephone:

Reserved for the supplier for complementary information, diagnosis, procedures, or other pertinent details.

☐ Duplicate

It is possible that the expenses listed in this claim are not covered by the plan in which I am participating or that they are covered only partially. It is therefore my responsibility to ensure that my dentist is paid for all treatments provided. I recognize that the total expense is $_____, that this amount is accurate, and that it was invoiced to me for treatments received. I consent that all information contained in the present claim be disclosed to the insurer or to the plan administrator.
I also authorize disclosure of information to the supplier mentioned concerning coverage of services described in this form.

_____
Signature of patient (of parent or of guardian)

Date of treatment (YYYY-MM-DD)	Procedure code	Tooth int. code	Tooth surface	Supplier fee	Lab fee	Total expense	Amount eligible	Code

The present is an accurate declaration of the treatments provided and the fees claimed, with no errors or omissions.

TOTAL EXPENSE CLAIMED

_____ Dentist's signature (a stamp is not accepted)

_____ Date (YYYY-MM-DD)

Attention: claims must be submitted within one year after the date on which the expense was incurred.

2. INFORMATION ON THE PRINCIPAL INSURANCE PLAN PARTICIPANT OR RETIREE

Last name _____ First name _____

Client no. _____ Date of birth (YYYY-MM-DD) _____

3. INFORMATION ON THE PATIENT

Last name _____ First name _____

1. Patient : relationship with the insurance plan participant _____

   If it is an adult child, is the child a full-time student? ☐ Yes ☐ No

   If child is a student, name of the educational institution* _____

   * If your child is between 18 and 21 years of age, the child must be single and attending a recognized educational institution full time to be eligible for a claim. You are required to notify us of all changes to your list of dependents. You may do so at any time by accessing your online services.

2. Are these dental treatments covered by another group insurance plan? ☐ Yes ☐ No If yes:

   Policy no. _____ Spouse's date of birth _____

   Name of other insurance company or plan _____

3. Are these treatments related to an event covered by a provincial plan? ☐ Yes ☐ No

   If yes, which organization? ☐ CNESST ☐ SAAQ ☐ IVAC

   Date of event (YYYY-MM-DD) _____ File no. _____

   The claim must first be submitted to the organization involved.

4. Are these treatments required following an accident? ☐ Yes ☐ No

   If yes, give the date and provide details on a separate sheet of paper. Date (YYYY-MM-DD) _____

5. If the treatment includes a prosthesis, crown, or bridge, is this the initial insertion? ☐ Yes ☐ No

   If no, give the date of the previous insertion and the reason for the replacement.

   Date (YYYY-MM-DD) _____ Reason _____

4. AUTHORIZATION

I am authorized by my spouse and/or dependents to disclose and receive information about them that is used for these purposes. I attest that the information provided in this claim is complete and accurate. For the purpose of administration and evaluation of the claims and for fraud prevention, I authorize Médic Construction to obtain personal, medical, and psychosocial information and disclose it to the plan administrators and to regulatory and law enforcement agencies. I understand that the information will be used and preserved by Médic Construction for administration of benefits. Unless expressly revoked, the present authorization remains in force for the duration of claim processing. The information may be seen by the cardholder.

_____ Mandatory signature by insured (employee or retiree)

_____ Signature of patient

_____ Date (YYYY-MM-DD)

The information given in this form is confidential.

This document is available in adapted media upon request.

CLAIM FOR A CROWN, FACET, INLAY, FIXED BRIDGE, OR PROSTHESIS

- **If it is for a crown, facet, or inlay,** submit radiographs before treatment. If it is a replacement, give the age of the existing apparatus.
- **If it is for a fixed bridge,** submit radiographs before treatment clearly showing both sides of the arch involved. If it is a replacement, give the age and type of existing prosthesis. If it is an initial insertion, give the date of extraction of the missing tooth.
- **If it is for replacement of a prosthesis,** give the age of the existing prosthesis.
- **If it is for initial insertion of a prosthesis,** give the date of extraction of the missing tooth.

Include a copy of the invoice for lab fees with your claim.

Please return this form and the documentation stapled to the back to this address:

Médic Construction
Section de l'assurance maladie
C. P. 2212, succursale Chabanel
Montréal (Québec) H2N 0B8

For further information, please call the CCQ's Customer Services at 1 888 842-8282 or visit ccq.org.

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