Reimbursement Request Cover Sheet

To accompany all requests for reimbursement
Cover Sheet must be completed in full to be approved for payment
NO FAXES ACCEPTED

Patient Name _____

Registration #_____ -_____ DOB: _____ / _____ / _____
Centre Number - Health Card Number Day Month Year

1. **Attach original standard dental claim form(s)/invoices(s).**

2a. Does the patient have private dental insurance?

Yes ☐ No ☐

Group Policy/Plan No. _____

Name of Insuring Agency _____

2b. Are any dental benefits or services provided under any other Insurance or dental plan, WSIB or government plan, litigation?

Yes ☐ No ☐

Group Policy/Plan No. _____

Name of Insuring Agency _____

If yes, attach original explanation of benefits/insurance cheque stub(s). No copies or faxes will be accepted.

3. Is the treatment associated with the claim complete? Yes ☐ No ☐

4. Please reimburse:

☐ Patient ☐ Parent/Guardian ☐ Dental Specialist ☐ Regional Centre

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

5. If there are any changes to patient/parent information (i.e., insurance coverage, address, phone number) please attach specifics.

_____ _____ _____
Submitted by –print name) **(Submitted by- signature)** **Date**

_____
Phone Number

PLEASE MAKE COPIES FOR YOUR USE

Please Note

All completed reimbursement requests must be sent to the following address:
Administrative Coordinator
Cleft Lip and Palate/Craniofacial Dental Program
555 University Avenue, Room S521
Toronto, ON M5G 1X8

(FAXES WILL NOT BE ACCEPTED)

Please contact (416) 813-5882 with questions regarding submission of Reimbursement Requests

March 2010