

PHYSICIAN'S STATEMENT

Physician: _____ Address: _____ Tel: (____) _____

Name of Hospital / Clinic : _____ Address: _____

Nature of Injury: _____ Date of First Attendance: ____/____/____

_____ Claimant will be totally disabled:

_____ From: _____ To: _____

Is the injury permanent and irrecoverable? No Yes

Give details of injury (degree) : _____

Prognosis for recovery : _____

Did any disease or previous injury contribute to the current injury? No Yes (describe): _____

Was claimant hospitalized? No Yes (give hospital name, address and date admitted): _____

Names and addresses of other physicians or surgeons, if any, who attended claimant: _____

I certify that the above information is correct to the best of my knowledge,

Signed: _____ Date: _____

DENTIST'S STATEMENT

Limits of coverage: \$1,000 per tooth, \$2,000 per accident
Treatment must be completed within 52 weeks of accident

		UNIQUE NO. SPEC. PATIENT'S OFFICIAL ACCOUNT NO.	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM DIRECTLY TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER
P A T I E N T	LAST NAME GIVEN NAME _____ ADDRESS APT. _____ CITY PROV. POSTAL CODE	D E N T I S T PHONE NO.	

FOR DENTIST'S USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION.

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY PLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREATMENT.

I ACKNOWLEDGE THAT THE TOTAL FEE OF \$ _____ IS ACCURATE AND HAS BEEN CHARGED TO ME FOR SERVICES RENDERED.

I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY/PLAN ADMINISTRATOR.

DUPLICATE FORM

SIGNATURE OF (PATIENT/GUARDIAN)

OFFICE VERIFICATION

DATE OF SERVICE DAY / MO. / YR.	PROCEDURE	INITIAL TOOTH CODE	TOOTH SURFACE	DENTIST'S FEE	LAB CHARGE	TOTAL CHARGE

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE & OE.

NOTE: All benefits subject to insurer payor status, provisions of the policy, Hockey Canada sanctioned events.

**TOTAL FEE
SUBMITTED**

Please fax to ODMHA at (613) 224-4625(GOAL) then mail original
ODMHA, 1247 Kilborn Place, Suite 300
Ottawa, ON K1H 6K9