CG | UNITED

DENTAL CLAIM FORM

Claim No. _____

Health Insurance

PROOF OF CLAIM MUST BE SUBMITTED WITHIN 90 DAYS OF FIRST DAY OF ACCIDENT OR ILLNESS.

Please submit completed form via Email to Medical_Claims_BB@cgcoralisle.com.

PART 1 To be completed by the EMPLOYEE/INSURED (please print)

Full Name of Insured _____

Effective and/or Termination Date (DD/MM/YY) _____

Group Policy No. _____ Certificate No. _____

Employer Name _____

Employer's Mailing Address _____ Tel. No. _____

Full Name of Patient _____

Patient's Mailing Address _____ Tel. No. _____

Patient's Date of Birth (DD/MM/YY) _____ Patient's Gender ☐ Male ☐ Female

Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____

If the patient has other Dental Insurance coverage, provide name of policy holder and policy number _____

Name of Dentist _____

Address of Dentist _____

DECLARATION: I hereby certify that the foregoing answers are true and correct to the best of my knowledge and hereby authorize all doctors, or other persons who treated me, and all hospitals or other institutions, to furnish full information including full copies of records regarding this claim to CG United Insurance Ltd.

Patient's or Authorised Person's Signature _____ Date _____

ASSIGNMENT OF BENEFIT: ☐ I hereby authorise payment of the Group Insurance Benefit directly to the Dentist named below for amounts otherwise payable to me.

Patient's or Authorised Person's Signature _____ Date _____

PART 2 To be completed by the ATTENDING DENTIST (please print)

Specialist in ☐ Orthodontics ☐ Endodontics ☐ Oral Surgery ☐ Periodontics ☐ Other _____

Date of first visit in current series (DD/MM/YY) _____ Dentist Tel. No. _____

TREATMENT DETAILS

1. If Prosthesis, is this the initial replacement? ☐ Yes ☐ No If No, date of prior replacement (DD/MM/YY) _____
2. Is this treatment for orthodontics? ☐ Yes ☐ No If Yes, date service commenced (DD/MM/YY) _____

Date appliances placed (DD/MM/YY) _____ Months of treatment remaining _____

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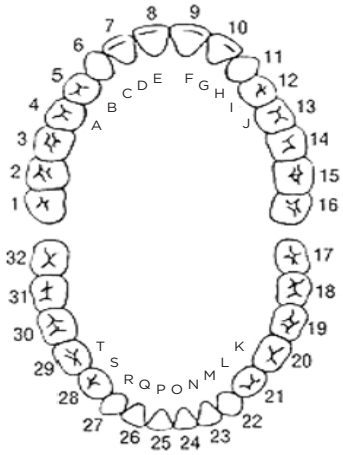

NOTES:

1. Examination Details to be completed on chart below.
2. Identify missing teeth with "X" on dental plan to right.
3. If services cannot be completed within 90 days from date of examination, patient must obtain a new authorisation and Claim Form for uncompleted services.
4. A pre-operative and post-operative x-ray of root canal work is required. Post-operative bite-wing x-rays must be provided when requested by CG United Insurance Ltd.

PART 3 EXAMINATION AND TREATMENT PLAN

List in order of tooth no. using the chart system shown

TOOTH No. OR LETTER	SURFACE	DENTAL CODE	DESCRIPTION OF SERVICE (Include x-rays, prophylaxis, materials used, etc.)	DATE OF SERVICE (DD/MM/YY)	FEE
				TOTAL FEE CHARGED	

INSTRUCTIONS

Tooth No/Letter	Using the tooth chart above, please indicate appicable tooth
Dental Code (see Part 6)	i.e. D####; e.g., D0120 = Periodic oral eval – established patient

PART 4 DENTIST'S CERTIFICATION FOR SERVICES PROVIDED

I have been paid. ☐ Yes ☐ No I certify the above items (no. of items_____) were provided and completed by me.

Signature_____ Date _____

PART 5 DECLARATION (To be signed by the Patient AFTER all the work is complete.)

I hereby certify that the procedures as indicated by "Date of Service" have been completed to my satisfaction.

Patient's Signature _____ Date _____

CG United Insurance Ltd.
Administered by Coralisle Medical Insurance Company Ltd.
www.CGUnited.com
Members of Coralisle Group Ltd.

Rev. 03-24

Health Insurance

PART 6 COMMON DENTAL PROCEDURE CODES

Note: Codes are for reference purposes only, not a summary of benefits.

DIAGNOSTIC	
Oral Evaluations	
D0120	Periodic oral evaluation - established patient
D0140	Limited oral evaluation - problem focused
D0150	Comprehensive oral evaluation - new established patient
D0160	Detailerd and extensive oral evaluation, problem focused by report
D0180	Comprehensive periodontal evaluation
Xrays/Radiographic Images	
D0210	Intraoral - complete series of radiogrpaic images
D0220	Intraoral - periapical first radiographic image
D0230	Introral - periapical first radiographic image
D0240	Intraoral - occlusal radiogrphic image
D0270	Bitewing - single radiographic image
D0272	Bitewings - two radiographic images
D0274	Bitewings - four radiographic images
D0330	Panoramic radiographic image
CASTS	
D0470	Diagnostic casts
PREVENTIVE	
Routine Cleanings	
D1110	Prophylaxis - adult
D1120	Prophylaxis - child
Other Preventive Service	
D1206	Topical application of fluoride with varnish
D1208	Topical application of fluoride excl. varnish
D1351	Sealant - per tooth
RESTORATIVE	
Fillings - Amalgam	
D2140	Amalgam - one surface, primary or permanent
D2150	Amalgam - two surfaces, primary or permanent
D2160	Amalgam - three surfaces, primary or permanent
Fillings - Resin	
D2330	Resin-based composite - one surface, anterior
D2331	Resin-based composite - two surfaces, anterior
D2332	Resin-based composite - three surfaces, anterior
D2335	Resin-based composite - four or more surfaces
D2391	Resin-based composite - one surface, posterior
D2392	Resin-based composite - two surfaces, posterior
D2393	Resin-based composite - three surfaces, posterior
D2394	Resin-based composite - four or more surfaces, posterior
Crowns	
D2710	Crown - resin-based composite (indirect)
D2740	Crown - porcelain/ceramic
D2750	Crown - porcelain fused to high noble metal
D2751	Crown - porcelain fused to predominantly base metal
D2752	Crown - porcelain fused to noble metal
D2792	Crown - full cast noble metal
Other Restorative Services	
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration
D2920	Re-cement or re-bond crown
D2930	Pre-fabricated stainless steel crown - primary tooth
D2940	Protective restoration
D2950	Core build-up, including any pins when required
D2952	Post and core in addition to crown, indirectly fabricated
D2954	Prefabricated post and core in addition to crown

ENDODONTICS	
Pulpotomy	
D3220	Therapeutic pulpotomy (excl. final restoration)
Endodontic Therapy (Root Canals)	
D3310	Endodontic therapy, anterior tooth (excl. final restoration)
D3320	Endodontic therapy, premolar tooth (excl. final restoration)
D3330	Endodontic therapy, molar tooth (excl. final restoration)
PERIODONTICS (SURGICAL SERVICE)	
Surgery	
D4260	Osseous surgery - four or more contiguous teeth or per quadrant
D4261	Osseous surgery - one to three contiguous teeth or per quadrant
D4263	Bone replacement graft, retained natural tooth, first site in quadrant
Periodontal Scaling and Root Planing	
D4341	Periodontal scaling and root planing - four or more teeth per quadrant
D4342	Periordontal scaling and root planing - one to three teeth per quadrant
D4355	Full mouth debridement to enable a comp oral eval/diag on a subsequent visit
Other Periodontic Services	
D4910	Periodontal maintenance
Prosthodontics (Dentures)	
D5110	Complete denture (maxillary)
D5211	Partial denture - resin-based (maxillary)
D5212	Partial denture - resin-based (mandibular)
D5650	Add tooth to existing partial denture
D6240	Pontic - porcelain fused to high noble metal
IMPLANTS	
D6010	Surgical placement of implant body: endosteal implant
D6240	Add tooth to existing partial denture
ORAL AND MAXILLOFACIAL SURGERY	
D7111	Extraction, coronal remnants - primary tooth
D7140	Extraction, erupted tooth or exposed root
D7210	Extraction, erupted tooth requiring removal of bone
D7220	Removal of impacted tooth - soft tissue
D7230	Removal of impacted tooth - partially bony
D7240	Removal of impacted tooth - completely bony
D7250	Removal of residual tooth roots (cutting procedure)
ORTHODONTICS	
D8030	Limited orthodontic treatment of the adolescent dentition
D8040	Limited orthodontic treatment of the adult dentition
D8070	Comp. Orthodontic treatment of the adolescent dentition
D8080	Comp. Orthodontic treatment of the adult dentition
Repair	
D8696	Repair of orthodontic applicance - maxillary
D8697	Repair of orthodontic applicance - mandibular
MISCELLANEOUS SERVICES	
D9110	Palliative (emergency) treatment of dental pain - minor procedure
D9222	Deep sedation/general anesthesia - first 15 minutes
D9223	Deep sedation/general anesthesia - each subsequent 15 minutes