Simcoe County Ontario Works

# CHILDREN'S DENTAL ONLY

Claim Form

***Claim form not valid without attaching copy of dental card for date of service***

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|---|---|---|
| **Social Services Case ID No:** | **OW Office:** | |
| **Patient's Last Name:** | **First Name:** | **M/F:** |
| **Patient's Health Card Number:** | **Date of Birth: (YYYY/MM/DD)** | |
| **Date of Issue of Claim Form (YYYY/MM/DD)** | **School:** | |
| **Mailing Address:** | | |
| **City/Town:** | **Province and Postal Code:** | |
| **Parent/Guardian Name:** | **Telephone:** | |

| Date of Service | | | Procedure Code | Tooth Code | Tooth Surfaces | Dentist's Fee | For Health Unit / Ontario Works Use Only | |
|---|---|---|---|---|---|---|---|---|
| YY | MM | DD | | | | | Line | Comments |
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**DENTIST**

**Phone No.** **UIN:**

**For dentist's use only – for additional information, diagnosis, procedures or special considerations, anaesthetist's name, or specialist's name ( & reason for referral)**

**Duplicate Form** ☐

**Treatment Plan is Still Incomplete** ☐

**Treatment Plan is Now Complete** ☐

**I understand that it is a condition of Ontario Works and the Ontario Disability Support Program that dentists not seek payment from the patients for OW/ODSP covered services. I agree to seek payment for OW/ODSP covered services only from Ontario Works or the Ontario Disability Support Program, and agree that this payment will constitute payment in full for those services. I have not, and will not seek payment from any other party including the patient, parent(s) or guardian(s).**

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**Dentist's Signature**

**I authorize the disclosure of my/my child's name, date of birth, address, telephone number, welfare status and case number, type of dental treatment and cost of treatment to the local plan administrator, the Ministries of Health and Community and Social Services and any other agency funding the treatment.**

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**Patient/Parent's Signature**

## Claim Verification for Health Unit Use Only

**H.U.#** 30 **OHISS Case #** **OHISS Claim #**

**Referral Date** **Y=Yes N=No** **OW** **ODSP**

**Source of Referral**
School Screening - S
Follow-up - F
Other - O

**Payment Arrangements**
Fee For Service - F
Sessional - S
Health Unit - H

**Amount Paid**

**Cheque No.**

**Date Paid**

**Information for Dentist:**

**Please return this form to:**

**Simcoe Muskoka District Health Unit**
**Barrie by the Bay, 403-80 Bradford Street**
**Barrie, ON L4N 6S7**
**telephone # (705) 721-7520 fax # (705) 734-9369**
**toll free # 1-877-721-7520 and ask for ext. 8810**

**This personal information is collected under the authority of s.41 (1) and (2) of the Ontario Works Act, 1997. The information will be used to provide administration of publicly funded dental assistance programs. Documents are maintained pursuant to the Municipal Freedom of Information and Protection of Privacy Act, 1991 and the Personal Health Information Protection Act, 2004. Questions regarding the collection and use of personal information should be directed to the Office of the Privacy Officer at the Board of Health listed to the left.**