Cowan

HEALTH & DENTAL CLAIM FORM

SECTION 1 – Member Information

Member Name (*Last Name, First Name*):		**Certificate Number:**
Address:		**Apt.:**
		Telephone Number:
City:	**Province:**	**Postal Code:**

SECTION 2 – Patient Information

Patient Name (*Last Name, First Name*):			**Date of Birth (*dd/mm/yyyy*):**
Relationship to Member:	**Self** ☐	**Spouse** ☐	**Dependent Child** ☐

SECTION 3 – Authorization (To be completed by member)

I, the undersigned, authorize the Cowan Insurance Group ("CIG"), my employer, my plan administrator, physician, health care professional, hospital, medical facility, insurance company, workers compensation board or similar plan or organization, federal, territorial or provincial government department, or any other corporation or organization, institution or association, to release and exchange with CIG, or its representatives, all medical or benefit payment information or any other information or records in its possession that CIG may hold or request for the purposes of adjudicating this claim.

I certify that the information I am submitting in support of my claim is true and complete to the best of my knowledge and belief. I understand that CIG may investigate my claim by collecting additional relevant personal information about me or my dependents from me and/or from other third parties. In cases of suspected fraud or plan abuse, CIG will investigate and I agree that CIG may share information with regulatory bodies, government or police agencies, healthcare professionals and the plan administrator or employer, if appropriate. I agree that a photocopy of this authorization shall be as valid as the original.

Date: _____ **Member Signature:** _____

SECTION 4 – Provider Information

Provider Name:	**Specialty:**	
Address:		**Postal Code:**
Provider I.D. Number:		**Telephone Number:**

Payment assignment to the Provider *(To be completed by member, applicable to providers in Canada only)*

Note: If payment is to be made to the provider, the member is to sign this section also.

I hereby assign my benefits payable from this claim to the named provider and authorize payment directly to him/her.

Date: _____ **Member Signature:** _____

SECTION 5 – Statement of Services

Patient Name	Service Date	Description of Service	Provincial Code (plus time units, if applicable)	Charge

I declare that the above is a correct statement of services rendered.

Date: _____ **Signature:** _____

Note: ****Dentists:*** a Standard Claim Form is preferred, complete with codes for services rendered.

DIRECT ALL CLAIM FORMS AND SUPPORTING DOCUMENTS TO:

Cowan Insurance Group Ltd.
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Ottawa (ON) K1J 9L8
Email: clients@cowangroup.ca
Tel.: 1-888-509-7797 Fax: 613-741-7771