



**GUARDIAN LIFE OF THE CARIBBEAN LIMITED
DENTAL PRE-CERTIFICATION
PROVIDER FORM: This form must be completed
when the estimated total or total dental treatment is
over \$500.00.**

DENTAL PRE-CERTIFICATION PROVIDER FORM

POLICYHOLDER: _____

INSURED: _____ **PATIENT:** _____

PROVIDER: _____ **YOUR FAX#:** _____

**KINDLY INDICATE ESTIMATED TREATMENT TO INCUR OVER THE NEXT
ON E (1) MONTH PERIOD ONLY**

TYPE OF SERVICE	ESTIMATED COST OF TREATMENT	NEMWIL LIABILITY	PATIENT LIABILITY
Examination:	\$ _____	\$ _____	\$ _____
X-Ray:	\$ _____	\$ _____	\$ _____
Fillings: Type _____	\$ _____	\$ _____	\$ _____
Fillings: Type _____	\$ _____	\$ _____	\$ _____
Fillings: Type _____	\$ _____	\$ _____	\$ _____
Fillings: Type _____	\$ _____	\$ _____	\$ _____
Scale & Polish:	\$ _____	\$ _____	\$ _____
Dentures: _____	\$ _____	\$ _____	\$ _____
Crown: _____	\$ _____	\$ _____	\$ _____
Bridge: _____	\$ _____	\$ _____	\$ _____
Root Canal: _____	\$ _____	\$ _____	\$ _____
Extraction: _____	\$ _____	\$ _____	\$ _____
Other Treatment: _____	\$ _____	\$ _____	\$ _____
Orthodontic Treatment: _____	\$ _____	\$ _____	\$ _____
TOTAL:	\$ _____	\$ _____	\$ _____

Dentist/Representative Signature/Stamp

Date

GLOC Representative Signature/Stamp

Date

Insured/Patient's Signature

Date

**NOTE: TREATMENT MUST BE COMPLETED WITHIN 30 DAYS
FROM THE DATE OF THIS AUTHORISATION.**