INSURANCE ADMINISTRATORS INC.
49 Industrial Dr., Elmira, ON N3B 3B1
(519) 669-1632 1-888-877-RWAM (7926)

STANDARD DENTAL CLAIM FORM

PART 1 DENTIST

UNIQUE NO. | SPEC. | PATIENTS OFFICE ACCOUNT NO.

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER

PATIENT

DENTIST

PHONE NO.

SIGNATURE OF SUBSCRIBER

FOR DENTIST'S USE ONLY – FOR ADDITIONAL INFORMATION DIAGNOSIS PROCEDURES OR SPECIAL CONSIDERATION

DUPLICATE FORM q

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. I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED TO THE COVERAGE OF SERVICES DESCRIBED IN THIS FORM TO THE NAMED DENTIST.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION

DATE OF SERVICE DAY MO. YR.	PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTISTS FEES	LABORATORY CHARGES	TOTAL CHARGES

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

TOTAL FEE SUBMITTED

FOR CARRIER USE

ALLOWED AMOUNT	INC.	%	PATIENT'S SHARE

CHEQUE NO. | DATE

DEDUCTIBLE | PATIENT PAYS | PLAN PAYS

CLAIM NO.

INSTRUCTIONS FOR CLAIMS SUBMISSION

BEING A STANDARD FORM, THIS FORM CANNOT INCLUDE SPECIFIC INSTRUCTIONS ON WHERE IT SHOULD BE SENT. DEPENDING ON WHO IS THE CARRIER FOR YOUR PLAN, YOU CAN OBTAIN DETAILS FROM EITHER YOUR PLAN BOOKLET, YOUR CERTIFICATE OR FROM YOUR EMPLOYER.

PART 2 – EMPLOYEE / PLAN MEMBER

GROUP POLICY / PLAN NO. _____ DIVISION NO. _____

EMPLOYER _____

NAME OF INSURING AGENCY OR PLAN _____

YOUR NAME _____

YOUR CERTIFICATE NO. _____

YOUR DATE OF BIRTH _____
DAY MONTH YEAR

PART 3 – PATIENT INFORMATION

1. PATIENT RELATIONSHIP TO EMPLOYEE / PLAN MEMBER _____

   DATE OF BIRTH (DD/MM/YY) _____

   IF CHILD INDICATE STUDENT O HANDICAPPED O

   IF STUDENT, INDICATE SCHOOL _____

   PATIENT I.D. NO. _____

2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN, W.C.B. OR GOVERNMENT PLAN? NO O YES O

   POLICY NO. _____ SPOUSE DATE OF BIRTH (DD/MM/YY) _____

   NAME OF OTHER INSURING AGENCY OR PLAN _____

3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? IF YES, GIVE DATE AND DETAILS SEPARATELY. NO O YES O

4. IF DENTURE , CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? NO O YES O

   IF NO, GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT _____

5. IS ANY TREATEMENT REQUIRED FOR ORTHODONTIC PURPOSES? NO O YES O

6. AUTHORIZATION: I UNDERSTAND THE INFORMATION I PROVIDE ON THIS FORM WILL BE USED TO DETERMINE MY ELIGIBILITY FOR DENTAL BENEFITS CLAIMED UNDER THIS POLICY/PLAN. I CERTIFY THAT THE CHARGES LISTED ABOVE AND FOR WHICH THE BILLS ARE ATTACHED, WERE INCURRED BY MYSELF OR ONE OF MY ELIGIBLE DEPENDENTS. I DECLARE THAT THE STATEMENTS MADE ON THIS FORM ARE COMPLETE AND TRUE. I HEREBY AUTHORIZE THE RELEASE TO RWAM INSURANCE ADMINISTRATORS INC., OF ANY INFORMATION IN RESPECT TO THIS DENTAL CLAIM REQUESTED BY RWAM. THIS AUTHORIZATION WILL REMAIN VALID FOR AS LONG AS I AM CLAIMING DENTAL BENEFITS OR SERVICE, OR REVOKED IN WRITING BY MYSELF.

   A PHOTOCOPY OR FACSIMILE TRANSMISSION OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.

DATE _____ SIGNATURE OF EMPLOYEE _____ PHONE NO. _____