DENTAL BENEFITS CLAIM FORM

BENEFIT PLAN ADMINISTERED BY:
BENEFIT PLAN ADMINISTRATORS (ATLANTIC) LIMITED

Canadian Dental Association

Canadian Life and Health Insurance Association Inc.

PART 1 DENTIST

UNIQUE NO. | SPEC. | PATIENT'S OFFICE ACCOUNT NO.

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

PATIENT

LAST NAME GIVEN NAME

ADDRESS APT.

CITY PROV. POSTAL CODE

DENTIST

PHONE NO.

SIGNATURE OF SUBSCRIBER

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

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.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION

DUPLICATE FORM ☐

DATE OF SERVICE DAY	MO	YR	PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

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

TOTAL FEE SUBMITTED

INSTRUCTIONS

IF CHARGES WILL BE $300 OR MORE, YOUR CLAIM SHOULD BE SUBMITTED FOR PREDETERMINATION OF BENEFITS.

ROUTINE ORAL EXAMINATIONS, SCALING AND CLEANING, FLUORIDE TREATMENTS, X-RAYS, BASIC RESTORATIONS AND EMERGENCY TREATMENT MAY BE PERFORMED BY YOUR DENTIST PRIOR TO SUBMITTING YOUR CLAIM FOR PREDETERMINATION OF BENEFITS.

X-RAYS MAY BE REQUESTED TO BE SUBMITTED FOR CROWNS OR BRIDGEWORK. X-RAYS WILL BE RETURNED PROMPTLY TO YOUR DENTIST.

MAIL ALL CLAIM FORMS, PREDETERMINATIONS AND X-RAYS TO:

BENEFIT PLAN ADMINISTRATORS (ATLANTIC) LIMITED

49-55 ELIZABETH AVENUE, SUITE 202
ST. JOHN'S, NEWFOUNDLAND A1A 1W9

PART 2 MEMBER'S STATEMENT *(Complete this part before taking the form to your dentist's office.)*

Remaining Balance assessed through Health Care Spending Account (HCSA) or; ☐
Entire claim assessed through the Health Care Spending Account (HCSA) ☐

LOCAL NO. **904**

1. MEMBER'S NAME: _____ IDENTIFICATION NO. _____
(PLEASE PRINT)
ADDRESS: _____ TELEPHONE NUMBER: (_____)_____
DATE OF BIRTH: Day_____ Mo._____ Yr._____

2. PATIENT: RELATIONSHIP TO MEMBER _____ DATE OF BIRTH _____
IF CHILD AGE 21 AND OVER, INDICATE ☐ FULL-TIME STUDENT ☐ HANDICAPPED
DATE ENROLLED _____ DATE COMPLETED _____

3. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE, GOV'T. AGENCY OR DENTAL PLAN? ☐ NO ☐ YES
POLICY NUMBER _____
NAME OF INSURING AGENCY _____
IF CLAIMS FOR A DEPENDENT CHILD, PLEASE INDICATE SPOUSE'S DATE OF BIRTH _____

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

5. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? ☐ NO ☐ YES
IF INITIAL PLACEMENT ADVISE DATE TEETH WERE EXTRACTED _____
AND ALL OTHER MISSING TEETH IN ARCH _____
IF REPLACEMENT GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT

AUTHORIZATION: I certify that the above information is true, correct and complete. I authorize Benefit Plan Administrators (Atlantic) Limited ("BPA") to collect and use personal information about me and/or my eligible dependents to process this claim and administer my benefit plan. I am aware BPA will keep my personal information confidential and safeguarded.

I am aware that BPA will only release personal information to my eligible dependents specific to their benefit entitlements. I understand that my personal information (and the personal information of my eligible dependents) may only be shared with health care practitioners, medical facilities, providers of health care/dental services or benefits administration services, provincial health insurance plans, insurance carriers, government agencies, and auditing or independent investigative organizations in order to verify eligibility for my benefit entitlements.

I understand that my social insurance number will be kept in strictest confidence and will only be used for income tax reporting purposes and to match my information with the correct member file. I consent to the collection, use and disclosure of personal information as stated above.

MEMBER'S SIGNATURE

DATE _____/_____/_____
DAY MONTH YEAR

6. IS YOUR DEPENDENT EMPLOYED? ☐ NO ☐ YES IS YOUR DEPENDENT ATTENDING SCHOOL? ☐ NO ☐ YES
IF SO, GIVE NAME OF EMPLOYER OR SCHOOL

YOUR CLAIM CANNOT BE PROCESSED UNLESS ALL QUESTIONS ARE ANSWERED IN FULL

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

POSSESSION OF THIS CLAIM FORM DOES NOT CONSTITUTE ELIGIBILITY FOR BENEFITS

DCF-NL-L904