



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

# STANDARD DENTAL CLAIM FORM

<b>PART 1 DENTIST</b>	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				SIGNATURE OF SUBSCRIBER _____
	DENTIST	PHONE NO. _____		

FOR DENTIST'S USE ONLY - FOR ADDITIONAL INFORMATION DIAGNOSIS PROCEDURES OR SPECIAL CONSIDERATION   DUPLICATE FORM <input type="checkbox"/>	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 _____
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DATE OF SERVICE DAY MO. YR.	PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTISTS FEES	LABORATORY CHARGES	TOTAL CHARGES	FOR CARRIER USE								
							ALLOWED AMOUNT	INC.	%	PATIENT'S SHARE					
THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE E & OE.							TOTAL FEE SUBMITTED	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. \_\_\_\_\_ YOUR NAME \_\_\_\_\_

EMPLOYER \_\_\_\_\_ YOUR CERTIFICATE NO. \_\_\_\_\_

NAME OF INSURING AGENCY OR PLAN \_\_\_\_\_ 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  HANDICAPPED

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  YES

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  YES

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

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

5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? NO  YES

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

DATE \_\_\_\_\_ SIGNATURE OF EMPLOYEE \_\_\_\_\_ PHONE NO. \_\_\_\_\_