



DENTAL CLAIM FORM

PART 1 - PROVIDER
Unique No. Spec Patient's Office Account No.
Patient Last Name Given Name
Address Apt.
City Prov. Postal Code
Phone No
Signature of Plan Member

For provider'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 provider 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 provider.
Signature of Patient (Parent/Guardian) _____

Duplicate Form [] Office Verification

Table with columns: Date of Service DAY MO YR., Procedure Code, Int'l Tooth Code, Tooth Surfaces, Provider's Fee, Laboratory Charges, Total Charges, Allowed Amount, Code

This is an accurate statement of services performed and the total fee due and payable, E & OE. TOTAL FEE SUBMITTED

INSTRUCTIONS FOR CLAIM SUBMISSION:

Please carefully fill in all pertinent areas and sign the completed form. (Refer to RBC Life Identification Card for correct patient information). Incomplete or incorrect claim forms will be returned or rejected and will result in a delay in reimbursement.

PART 2 - EMPLOYEE/PLAN MEMBER
All claims must be submitted within 12 months of the date of service (unless otherwise stated in your benefit plan documentation).
Plan Member's Name (Please Print) Plan Member's Identification Number Plan Member's Date of Birth
Last Name Given Names

PART 3 - PATIENT INFORMATION
Patient's Name (Please print) Patient's Identification Number Patient's Date of Birth
Last Name Given Names
1. Patient: Relationship to Plan Member
If child, indicate: Student [] Handicapped []
If student, indicate school
2. Are any dental benefits or services provided under any other group insurance or dental plan, W.S.I.B. or Government plan?
If Yes, Policy No. Spouse Date of Birth
Name of other insuring Agency or Plan
3. Is any treatment required as the result of an accident?
4. If denture, crown or bridge, is this initial placement?
5. Is any treatment required for orthodontic purposes?
I authorize the release of any information or records required in respect of this claim to insurer/plan administrator and certify that the information given is true, correct and complete to the best of my knowledge.
Signature of Plan Member Date

All information recorded on this form is confidential.
I am authorized by my spouse and/or dependents to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder. By signing this claim form and/or submitting actual receipts, I agree that the information provided is complete and accurate. I understand that the information provided by me to RBC Life about myself and my dependents, will be used by RBC Life for claims adjudication and any other services necessary in the administration of our benefits which may include the exchange of information with other parties to administer this benefit claim. I further authorize RBC Life to obtain and exchange information with other parties, such as health practitioners or insurers, in order to confirm the accuracy of the submitted claim(s) information. In the event of suspected fraudulent activity pertaining to claims submitted on behalf of myself and/or my dependents, I acknowledge and agree to the disclosure of this information to relevant parties, such as the Plan Sponsor, regulatory and law enforcement agencies.