



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



Brock University Students' Union

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 <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	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. 490007 DIVISION NO. 1 YOUR NAME _____

UNIVERSITY BROCK UNIVERSITY STUDENT PLAN STUDENT IDENTIFICATION NUMBER. _____

NAME OF INSURING AGENCY OR PLAN RWAM INSURANCE ADMINISTRATORS INC. YOUR DATE OF BIRTH _____

DAY MONTH YEAR

PART 3 – PATIENT INFORMATION

<p>1. PATIENT RELATIONSHIP TO EMPLOYEE / PLAN MEMBER _____</p> <p>DATE OF BIRTH (DD/MM/YY) _____</p> <p>IF CHILD INDICATE STUDENT <input type="checkbox"/> HANDICAPPED <input type="checkbox"/></p> <p>IF STUDENT, INDICATE SCHOOL _____</p> <p>PATIENT I.D. NO. _____</p> <p>2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN, W.C.B. OR GOVERNMENT PLAN? NO <input type="checkbox"/> YES <input type="checkbox"/></p> <p>POLICY NO. _____ SPOUSE DATE OF BIRTH (DD/MM/YY) _____</p> <p>NAME OF OTHER INSURING AGENCY OR PLAN _____</p> <p>DATE _____ SIGNATURE OF EMPLOYEE _____</p>	<p>3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? IF YES, GIVE DATE AND DETAILS SEPARATELY. NO <input type="checkbox"/> YES <input type="checkbox"/></p> <p>4. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? NO <input type="checkbox"/> YES <input type="checkbox"/></p> <p>IF NO, GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT _____</p> <p>5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? NO <input type="checkbox"/> YES <input type="checkbox"/></p> <p>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.</p> <p>A PHOTOCOPIED OR FACSIMILE TRANSMISSION OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.</p> <p style="text-align: right;">PHONE NO. _____</p>
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