

**RWAM****INSURANCE ADMINISTRATORS INC.**
49 Industrial Dr., Elmira, ON N3B 3B1**STANDARD DENTAL
CLAIM FORM**

PART 1 DENTIST		UNIQUE NO.	SPEC.	PATIENTS OFFICE ACCOUNT NO.	NOT APPLICABLE
PATIENT	DENTIST	PHONE NO.			
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. I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED TO THE COVERAGE OF SERVICES DESCRIBED IN THIS FORM TO THE NAMED DENTIST.	
DUPLICATE FORM				SIGNATURE OF PATIENT (PARENT/GUARDIAN)	
				OFFICE VERIFICATION	
DATE OF SERVICE DAY MO. YR.				FOR CARRIER USE	
PROCEDURE CODE				ALLOWED AMOUNT	
INTL. TOOTH CODE				INC.	
TOOTH SURFACES				%	
DENTISTS FEES				PATIENT'S SHARE	
LABORATORY CHARGES					
TOTAL CHARGES					
THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE E & OE.				TOTAL FEE SUBMITTED	
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 <u>RWAM INSURANCE ADMINISTRATORS INC.</u>			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 <input type="radio"/> HANDICAPPED <input type="radio"/> IF STUDENT, INDICATE SCHOOL _____ PATIENT I.D. NO. _____			3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? IF YES, GIVE DATE AND DETAILS SEPARATELY. NO <input type="radio"/> YES <input type="radio"/> 4. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? NO <input type="radio"/> YES <input type="radio"/> IF NO, GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT _____ 5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? NO <input type="radio"/> YES <input type="radio"/> 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.		
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="radio"/> YES <input type="radio"/> POLICY NO. _____ SPOUSE DATE OF BIRTH (DD/MM/YY) _____ NAME OF OTHER INSURING AGENCY OR PLAN _____					
DATE _____			SIGNATURE OF EMPLOYEE _____		PHONE NO. _____