BOILERMAKERS LODGE NO. 191 BENEFIT PLAN

Hosted by the Boilermakers' National Health Plan (Canada)

45 McINTOSH DRIVE, MARKHAM, ON L3R 8C7
Phone: 1-800-263-3564 Fax: 905-946-2535
email: questions@boilermakers191benefits.org

STANDARD DENTAL CLAIM FORM

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 THEM.

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.

DUPLICATE FORM ☐

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 THE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO THE PLAN, MY INSURER,AND MY POLICYHOLDER. THE INFORMATION RELEASED THROUGH THIS AUTHORIZATION IS TO BE USED FOR CLAIMS ADJUDICATION PURPOSES AND STATISTICAL ANALYSIS.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION/DENTIST'S SIGNATURE

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

FOR CARRIER USE

CLAIM NUMBER

IF YOUR DENTIST RECOMMENDS A COURSE OF TREATMENT INVOLVING FEES OF $600.00 OR MORE, THEIR TREATMENT PLAN MAY BE SUBMITTED TO THE PLAN IN ADVANCE FOR PREDETERMINATION OF BENEFITS. THE PLAN WILL INFORM YOU , BEFORE YOU UNDERTAKE TREATMENT, OF THE AMOUNT ALLOWED BY THE PLAN.

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

TOTAL FEE SUBMITTED

INSTRUCTIONS FOR CLAIM SUBMISSION

1. HAVE THE ATTENDING DENTIST COMPLETE PART 1.
2. COMPLETE PARTS 2 AND 3 BELOW ON EACH FORM SENT IN.
3. ALL PARTS OF THIS FORM MUST BE COMPLETED IN FULL. IF NEEDED INFORMATION IS MISSING, THE FORM MAY BE RETURNED TO YOU.
4. **ALL CORRESPONDENCE, CLAIM FORMS, ETC. . . . MAIL TO: PLAN ADMINISTRATION OFFICE**

PART 2 — MEMBER

1. CONTROL NO./PLAN NO. _____ BRANCH NO. _____

EMPLOYER _____

2. NAME OF MEMBER _____

ADDRESS OF MEMBER _____

MEMBER'S DATE OF BIRTH: YEAR _____ MONTH _____ DAY _____

MEMBER'S SOCIAL INSURANCE NUMBER/IDENTITY NUMBER _____

PART 3 — PATIENT INFORMATION

1. PATIENT: RELATIONSHIP TO MEMBER _____

DATE OF BIRTH: YEAR _____ MONTH ☐☐ DAY _____

2. IF CLAIM IS FOR DEPENDENT CHILD, IS THAT CHILD

HANDICAPPED? ☐ YES NO ☐ MARRIED? ☐ YES NO ☐

A FULL TIME STUDENT? ☐ YES NO ☐ EMPLOYED? ☐ YES NO ☐

3. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER PLAN OF INSURANCE OR DENTAL SERVICES: ☐ YES NO ☐ IF "YES," PROVIDE:

POLICY NUMBER: _____

NAME OF INSURER: _____

SPOUSE'S NAME: _____

SPOUSE'S DATE OF BIRTH: YEAR _____ MONTH _____ DAY _____

4. IS ANY OF THE ABOVE WORK FOR ORTHODONTIC PURPOSES? ☐ YES NO ☐

5. A) IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? ☐ YES NO ☐

GIVE DATE AND DETAILS _____

B) IS CLAIM BEING MADE FOR WORKERS' COMPENSATION BENEFITS? ☐ YES NO ☐

6. IF THE TREATMENT INVOLVES THE PLACEMENT OF A BRIDGE, DENTURE OR CROWN:
A) IS THIS THE INITIAL PLACEMENT?

UPPER ☐ YES NO ☐ LOWER ☐ YES NO ☐

B) IF "NO" GIVE THE DATE OF PRIOR PLACEMENT AND THE REASON FOR REPLACEMENT

C) DATE OF EXTRACTIONS _____

Privacy Statement: I authorize the Boilermakers Lodge No. 191 Benefit and Pension Plans (together called "the Plans"), their administrator Employee Benefit Plan Services Limited, and providers working with the Plans or administrator to collect, maintain, use and disclose my personal information that is necessary for the administration of the Plans. Personal information will be protected pursuant to the applicable legislation. The Plans may collect, maintain, use and disclose my personal information with relevant persons or organizations (employers, health benefit managers, health professionals, institutions, insurers, investigative agencies, legal counsel, other plans or unions, pharmacies, regulators, re-insurers) in order to manage the Plans and entitlement to the benefits of the Plans, and may include information such as financial, health or benefits related information. Questions related to the Privacy Statement should be directed to the Privacy Officer

MEMBER'S SIGNATURE: _____

DATE: YEAR _____ MONTH _____ DAY _____

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL