NDT Benefits
Career — Health — Security

NDT Industry Health Benefit Plan

4250 CANADA WAY, BURNABY, BC V5G 4W6 Tel: (604) 299-7482 Fax: (604) 299-8136
Toll Free: 1-800-663-1356 www.ndtbenefits.org

STANDARD DENTAL CLAIM FORM

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 HIM/HER.

SIGNATURE OF SUBSCRIBER

PATIENT

LAST NAME | GIVEN NAME

ADDRESS | APT.

CITY | PROV. | POSTAL CODE

DENTIST

PHONE NO.

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 D.A. TOWNLEY, 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			PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES
YR.	MO.	DAY						

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

TOTAL FEE SUBMITTED

FOR CARRIER USE

CLAIM NUMBER

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

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: D.A. TOWNLEY**

PART 2 — MEMBER

1. CONTROL NO./PLAN NO. **52565** BRANCH NO. ______

   EMPLOYER ______
2. NAME OF MEMBER ______

ADDRESS OF MEMBER ______

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

MEMBER'S CERTIFICATE/I.D. 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 ______

   I UNDERSTAND THAT D.A. TOWNLEY COLLECTS PERSONAL INFORMATION TO ASSESS ELIGIBILITY FOR BENEFITS; TO DETERMINE AND ADJUDICATE BENEFITS, TO DETERMINE THE COST AND FINANCIALLY MANAGE THESE BENEFITS, AS WELL AS TO MEET REGULATORY OR CONTRACTUAL REQUIREMENTS RELATING TO SUCH BENEFITS AND SERVICES PROVIDED. I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO D.A. TOWNLEY, MY INSURER, AND MY POLICYHOLDER AND CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE, TO THE BEST OF MY KNOWLEDGE. THE INFORMATION RELEASED THROUGH THIS AUTHORIZATION WILL BE USED FOR CLAIMS ADJUDICATION PURPOSES AND STATISTICAL ANALYSIS.

MEMBER'S SIGNATURE: ______

DATE: YEAR ______ MONTH ______ DAY ______