THE EDMONTON PIPE INDUSTRY HEALTH AND WELFARE PLAN

DENTAL BENEFIT CLAIM FORM

PART 1 DENTIST

UNIQUE NO. SPEC PATIENT'S OFFICE ACCOUNT NO.

I HEREBY ASSIGN MY BENEFIT PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM / HER.

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.

I UNDERSTAND THAT THE FEES I LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY PLAN BENEFTIS. 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 FORM TO MY INSURING COMPANY / PLAN ADMINISTRATOR.

OFFICE VERIFICATION / DENTIST'S SIGNATURE _____

SIGNATURE OF PATIENT (PARENT / GUARDIAN) _____

DUPLICATE FORM ☐

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

COMPLETION INSTRUCTIONS

1. MEMBER COMPLETES PART 2 AND PART 3.
2. DENTIST COMPLETES PART 1.
3. IF YOU WISH BENEFITS TO BE PAID DIRECTLY TO THE DENTIST, SIGN THE ASSIGNMENT PORTION OF PART 1 ABOVE. ASSIGNMENT OF BENEFITS IS IRREVOCABLE.
4. SEND THIS CLAIM TO:
   THE EDMONTON PIPE INDUSTRY HEALTH AND WELFARE PLAN
   ADMINISTRATION OFFICE
   16214 - 118 AVENUE
   EDMONTON, ALBERTA T5V 1M6
   TELEPHONE: (780) 452-1331
5. **CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS OF SERVICE DATE.**

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

PART 2 MEMBER IDENTIFICATION

MEMBER'S NAME _____

MEMBER'S SOCIAL INSURANCE NUMBER _____ – _____ – _____

AUTHORIZATION AND SIGNATURE:
I certify that, if this claim is being made on behalf of my Spouse and/or Dependents, I am authorized to disclose information about them for the purposes of assessing and paying a benefit if any. I certify that the information given is true, correct and complete to the best of my knowledge. I authorize the use of my Social Insurance Number for claim identification purposes only. I understand that this information will be protected pursuant to the relevant legislation. I authorize the Administrator, its agents and service providers to use and exchange information needed for administering and adjudicating claims under this Plan with any person or organization who has relevant information pertaining to this claim, including Health Professionals, Institutions, Investigative Agencies, Re-Insurers and Regulators. I understand that information pertaining to this claim may be reviewed in the event that this Plan is audited.

Please complete all of the above information. The claim will be returned if any information is missing. **SIGNATURE** _____

PART 3 MEMBER'S STATEMENT (please print)

1. PATIENT'S RELATIONSHIP TO MEMBER
2. PATIENT'S DATE OF BIRTH _____ / _____ / _____ (DAY MONTH YEAR)
3. IF THE PATIENT IS A CHILD, DOES THE PATIENT RESIDE WITH YOU? YES ☐ NO ☐
4. IF THE PATIENT IS A CHILD OVER 18
   A) IS HE / SHE A FULL-TIME STUDENT? YES ☐ NO ☐ IF YES, NAME OF SCHOOL _____
   B) IS HE / SHE EMPLOYED? YES ☐ NO ☐ IF YES, HOW MANY HOURS WORKED PER WEEK? _____
5. A) ARE YOU OR ANY MEMBER OF YOUR FAMILY ENTITLED TO BENEFITS FROM ANY OTHER SOURCE? YES ☐ NO ☐
   IF YES, GIVE NAME AND ADDRESS OF OTHER SOURCE.
   _____

NAME OF FAMILY MEMBER INSURED _____ POLICY # _____

B) IS ANY MEMBER OF YOUR FAMILY (OTHER THAN YOURSELF) INSURED AS A MEMBER UNDER THIS PLAN? YES ☐ NO ☐

IF YES, NAME OF FAMILY MEMBER _____

C) IF YES TO A) OR B) ABOVE, AND THE PATIENT IS A DEPENDENT CHILD PLEASE PROVIDE SPOUSE'S DATE OF BIRTH _____ / _____ / _____ (DAY MONTH YEAR)

6. IS TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? YES ☐ NO ☐ IF YES, GIVE DATE, LOCATION, AND EXPLAIN HOW ACCIDENT HAPPENED
   _____
7. IF CLAIM IS FOR DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? YES ☐ NO ☐ IF NO, GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT
   _____

THIS BENEFIT IS NOT INSURED. DENTAL BENEFITS ARE FUNDED SOLELY BY THE ASSETS OF THE EDMONTON PIPE INDUSTRY HEALTH AND WELFARE FUND.