ALBERTA RETIRED TEACHERS' ASSOCIATION

P.O. BOX 1608 Windsor, Ontario N9A 7G1
Attn: Dental Department
Plan Member Inquiries: Member Support Centre 1-855-444-ARTA

DENTAL CARE CLAIM FORM

PART 1 - PROVIDER	Unique No.	Spec	Patient's Office Account No.	I hereby assign my benefits payable from this claim to the named provider and authorized payment directly to him/her.
PATIENT Patient Last Name Given Name Address Apt. City Prov. Postal Code	PROVIDER Phone No			Signature of Plan Member

For provider'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 provider 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 commnunication of information related to the coverage of services described in this form to the named provider.

Signature of Patient (Parent/Guardian) _____

Duplicate Form ☐

Office Verification

Date of Service DAY MO YR	Procedure Code	Int'l Tooth Code	Tooth Surfaces	Provider's Fee	Laboratory Charges	Total Charges	Allowed Amount	Code

This is an accurate statement of services performed and the total fee due and payable, E & OE.

TOTAL FEE SUBMITTED

INSTRUCTIONS FOR CLAIM SUBMISSION:

Please carefully fill in all pertinent areas and sign the completed form. (Refer to Alberta Retired Teachers' Association Identification Card for correct patient information). Incomplete or incorrect claim forms will be returned or rejected and will result in a delay in reimbursment.

PART 2 - EMPLOYEE/PLAN MEMBER

All claims must be submitted by December 31 of the following calendar year of the date of service.

Plan Member's Name (Please Print) | Benefit ID Number | Plan Member's Date of Birth Yr Mo Day |_____|_____|_____|

Last Name Given Names

PART 3 - PATIENT INFORMATION

Patient's Name (Please print) | Patient's Identification Number | Patient's Date of Birth Yr Mo Day |_____|_____|_____|

_____ _____ _____--_____

Last Name Given Names

1. Patient Relationship to Plan Member _____
   If child, indicate: Student ☐ Handicapped ☐
   If student, indicate school _____

2. Are any dental benefits or services provided under any other group insurance or dental plan, W.S.I.B. or Government plan? No ☐ Yes ☐
   If Yes, Policy No. _____ Spouse Date of Birth _____
   Name of other insuring Agency or Plan _____

3. Is any treatment required as the result of an accident? if Yes, give date and details separately. No ☐ Yes ☐

4. If denture, crown or bridge, is this initial placement? Give date of prior placement and reason for replacement. No ☐ Yes ☐

5. Is any treatment required for orthodontic purposes? No ☐ Yes ☐

I authorize the release of any information or records required in respect of this claim to insurer/plan administrator and certify that the information given is true, correct and complete to the best of my knowledge.

_____ Date _____
Signature of Plan Member Day Month Year

All information recorded on this form is confidential.

I am authorized by my spouse and/or dependents to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder.
By signing this claim form and/or submitting actual receipts, I agree that the information provided is complete and accurate. I understand that the information provided by me to Alberta Retired Teachers' Association about myself and my dependents, will be used by Alberta Retired Teachers' Association for claims adjudication and any other services necessary in the administration of our benefits which may include the exchange of information with other parties to administer this benefit claim.
I further authorize Alberta Retired Teachers' Association to obtain and exchange information with other parties, such as health practitioners or insurers, in order to confirm the accuracy of the submitted claim(s) information. In the event of suspected fraudulent activity pertaining to claims submitted on behalf of myself and/or my dependents, I acknowledge and agree to the disclosure of this information to relevant parties, such as the Plan Sponsor, regulatory and law enforcement agencies.