Insurance Information

Insurance at an Orthodontist's office differs from insurance at a General Dentist's office in four ways:

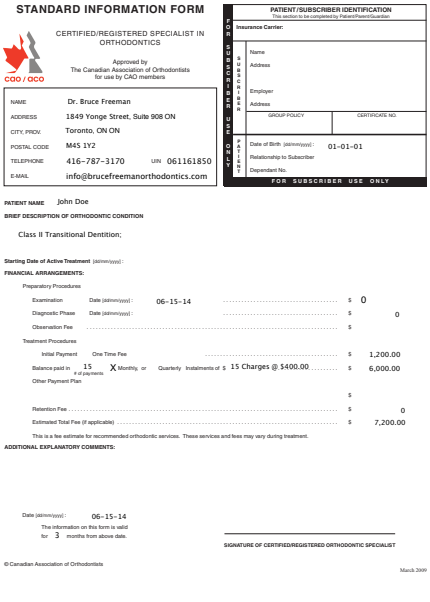
- There are no dental codes for services provided by an Orthodontist
- Orthodontists cannot receive reimbursement from insurance companies
- Orthodontists cannot send claims electronically
- Orthodontists produce a *Standard Information Form* which your insurance carrier requires before reimbursing you

The Standard Information Form

The Standard Information Form only needs to be submitted ONCE – either ahead of or at the same time as your first receipt. If you are unsure of your orthodontic insurance, we recommend that you submit the form ahead of time. After receiving the form, your insurance carrier will send you back written confirmation of your orthodontic insurance. Please note that the Standard Information Form is the only form that Dr. Freeman or Dr. Stevens will ever have to sign during treatment. To complete the form, simply fill out the box at the top right of the page that says "FOR SUBSCRIBER USE ONLY."

How to Receive Reimbursement

1. If you haven't already done so, complete the Standard Information Form (as described above)
2. Fill out a Dental Claim Form which you can obtain online from your insurance carrier or from your employer. An example is on the back of this page.
    a. In Part 1, complete the "Patient" box along with the information pertaining to your payment. Write down the date of payment (which is on your receipt) along with the description ORTHODONTICS.
    b. Please note that you do not require Office Verification. The dentist section does not need to be filled out and you do not require a stamp.
    c. Complete Part 2 and 3
3. Submit the 2 or 3 documents to your insurance carrier. If it is your first time submitting, remember that the Standard Information Form only needs to be submitted once. Your subsequent submissions will just include a receipt and a Dental Claim Form.



STANDARD INFORMATION FORM

CERTIFIED/REGISTERED SPECIALIST IN ORTHODONTICS

Approved by The Canadian Association of Orthodontists for use by CAO members

NAME Dr. Bruce Freeman
ADDRESS 1849 Yonge Street, Suite 908 ON
CITY, PROV. Toronto, ON ON
POSTAL CODE M4S 1Y2
TELEPHONE 416-787-3170 UIN 061161850
E-MAIL info@brucefreemanorthodontics.com

PATIENT/SUBSCRIBER IDENTIFICATION
This section to be completed by Patient/Parent/Guardian

FOR SUBSCRIBER USE ONLY

Insurance Carrier:
Name
Address
Employer
Address
GROUP POLICY
CERTIFICATE NO.
Date of Birth (dd/mm/yyyy): 01-01-01
Relationship to Subscriber
Dependant No.

FOR SUBSCRIBER USE ONLY

PATIENT NAME John Doe

BRIEF DESCRIPTION OF ORTHODONTIC CONDITION

Class II Transitional Dentition;

Starting Date of Active Treatment (dd/mm/yyyy):

FINANCIAL ARRANGEMENTS:

Preparatory Procedures
Examination Date (dd/mm/yyyy): 06-15-14 $ 0
Diagnostic Phase Date (dd/mm/yyyy): $ 0
Observation Fee $
Treatment Procedures
Initial Payment One Time Fee $ 1,200.00
Balance paid in 15 # of payments X Monthly, or Quarterly Instalments of $ 15 Charges @ $400.00 $ 6,000.00
Other Payment Plan $
Retention Fee $ 0
Estimated Total Fee (if applicable) $ 7,200.00

This is a fee estimate for recommended orthodontic services. These services and fees may vary during treatment.

ADDITIONAL EXPLANATORY COMMENTS:

Date (dd/mm/yyyy): 06-15-14
The information on this form is valid for 3 months from above date.

SIGNATURE OF CERTIFIED/REGISTERED ORTHODONTIC SPECIALIST

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March 2009

Additional Information

- Keep a photocopy of all receipts submitted to your insurance carrier as any unpaid portion may be able to be claimed as a deduction on your Income Tax Return
- If you have dual insurance, the Standard Information Form needs to be submitted to both insurance carriers initially. Subsequent submissions need to be sent first to the policy holder with the birthday (month and day) that falls earlier in the calendar year.
- If you wish to pay in full, the process is different. Please consult with us.
- Consult with your insurance carrier to see if they allow for online reimbursement submissions.

CANADIAN DENTAL ASSOCIATION

Canadian Life and Health Insurance Association Inc.

STANDARD DENTAL CLAIM FORM

PART 1 DENTIST

UNIQUE NO. | SPEC. | PATIENTS OFFICE ACCOUNT NO.

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

SIGNATURE OF SUBSCRIBER

PATIENT

DENTIST

PHONE NO.

FOR DENTIST USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES,OR SPECIAL CONSIDERATIONS.

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.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION

DATE OF SERVICE DAY MO. YR.	PRO-CEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES
DD/MM/YY	ORTHODONTICS					$XXX.XX

FOR CARRIER USE

ALLOWED AMOUNT	INC	%	PATIENT'S SHARE

CHEQUE NO. | DATE

DEDUCTIBLE	PATIENT PAYS	PLAN PAYS

CLAIM NO.

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

TOTAL FEE SUBMITTED $XXX.XX

INSTRUCTIONS FOR CLAIM 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.
IF YOU PLAN REQUIRES SUBMISSION DIRECTLY TO THE CARRIER, PLEASE SEND THIS FORM WITH ONLY PARTS 1, 2 AND 3 COMPLETED TO THE CARRIER'S APPROPRIATE CLAIMS OFFICE.
*IF YOUR PLAN REQUIRES SUBMISSION TO YOUR EMPLOYER, PLEASE DIRECT THIS FORM TO YOUR PERSONNEL OFFICE/PLAN ADMINISTRATOR WHO WILL COMPLETE PART 4 AND FORWARD THE FORM TO THE CARRIER.

PART 2 - EMPLOYEE/PLAN MEMBER/SUBSCRIBER

1. GROUP POLICY/PLAN NO._____DIVISION/SECTION NO._____

2. YOUR NAME (PLEASE PRINT) _____

EMPLOYER _____

YOUR CERT. NO. OR S.I.N. OR I.D. NO. _____

NAME OF INSURING AGENCY OR PLAN _____

YOUR DATE OF BIRTH _____
DAY MONTH YEAR

PART 3 - PATIENT INFORMATION

1. PATIENT: RELATIONSHIP TO EMPLOYEE/ PLAN MEMBER/SUBSCRIBER _____

DATE OF BIRTH _____ IF CHILD INDICATE: ❑ STUDENT ❑ HANDICAPPED
DAY MONTH YEAR

IF STUDENT, INDICATE SCHOOL _____

PATIENT I.D. NO. _____

2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURACE OR DENTAL PLAN, W.C.B. OR GOV'T PLAN? ❑ NO ❑ 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 SEPERATELY. ❑ 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

6. I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO THE INSURER / PLAN ADMINISTRATOR AND CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

DATE _____
DAY MONTH YEAR

SIGNATURE OF EMPLOYEE/PLAN MEMBER/SUBSCRIBER

PART 4. - POLICY HOLDER/EMPLOYER (FOR COMPLETION ONLY IF APPLICABLE. SEE ABOVE*)

	DAY	MONTH	YEAR
1. DATE COVERAGE COMMENCED			
2. DATE DEPENDENT COVERED			
3. DATE TERMINATED			

4. CONTRACT HOLDER

DATE					
DAY		MONTH		YEAR	

AUTHORIZED SIGNATURE

(POSITION OR TITLE)

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL