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. <u>Please note that the Standard Information</u> Form is the only form that Dr. Freeman or Dr. Caro or Dr. Lands 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.

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.

STANDARD INFORMATION FORM				PATIENT/SUBSCRIBER IDENTIFICATION This section to be completed by Patient/Fauerofication					
14	CERTIFIED/REGISTERED		e in	eurance Carrier:	_				
<u> </u>	ORTHODON	rics	ŝ	Name					
ao / aco	Approved b The Canadian Association for use by CAD m	d Orthoriontists	311 8 - 3 0 1 8 C 1	Address					
NAME	Dr. Bruce Freeman			Employer					
ADDRESS	1849 Yonge Street, Suit	e 908 ON	U	GROUP POLICY	1	CERTIFICATE NO.			
CITY, PROV.	Toronto, ON ON		2						
POSTAL CODE	M4S 1Y2		9 Å	Date of Birth (ds/mm/yyyy):	01-01-	01			
TELEPHONE	416-787-3170	un 061161850	E L	Relationship to Subscriber					
E-MAL	info@brucefreemano	rthodontics.com	ΥŅ	Dependant No. FOR SUDSORI					
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STANDARD DENTAL CLAIM FORM

PART 1 DENTIST	UNIQUE NO. SPEC.		PATIENTS OFFIC	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM To the named dentist and authorize payment to HIM/Her								
P A T I E N T	D E N T I S PHONE NO. T					NATURE OF S	JBSCRIBER					
FOR DENTIST USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDUF	IS.	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 MF 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)										
DATE OF SERVICE PRO- INTL.	OFFICE VERIFICATION											
	ENTIST'S LABORAT Fee charg	ORY ie	TOTAL CHARGES			FOR CARRIER USE						
DD/MM/YY ORTHODONTICS			\$XXX.XX	ALLOWED A	IMOUNT INC	%	PATIENT'S SHARE					
				CHEQUE NO.		DATE						
				DEDUCTIBL	LE PATIEN	T PAYS	PLAN PAYS					
THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE.	L FEE SUBMITTED		\$XXX.XX	CLAIM NO.								
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 centificate 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 NODIVISION/SECTION	I NO	2. Y	OUR NAME (PLEASE PRINT) _									
EMPLOYER		YOU	IR CERT. NO. OR S.I.N. OR I.D.	NO								
NAME OF INSURING AGENCY OR PLAN		YOU	IR DATE OF BIRTH DAY	Y MONTH YEA	R							
PART 3 - PATIENT INFORMATION												
1. PATIENT: RELATIONSHIP TO EMPLOYEE/ Plan Member/Subscriber			S ANY TREATMENT REQUIRED F YES, GIVE DATE AND DETAIL		AN ACCIDENT?	NO C	YES					
DATE OF BIRTH IF CHILD INDICATE: STUDENT CHANDICAPPED			4. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT. NO S. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES?									
IF STUDENT, INDICATE SCHOOL			5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES?									
PATIENT I.D. NO 2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROU PLAN, W.C.B. OR GOV'T PLAN?	P INSURACE OR DENTAL	т	AUTHORIZE THE RELEASE OF THE INSURER / PLAN ADMINIS COMPLETE TO THE BEST OF M	TRATOR AND CERTIF								
POLICY NO. SPOUSE DATE OF BIRTH					D	ATE Day	MONTH YEAR					
NAME OF OTHER INSURING AGENCY OR PLAN			SIGNATURE OF EMPLOYEE/PI	AN MEMBER/SUBSC	RIBER							
PART 4 POLICY HOLDER/EMPLOYER (FOR COMPLETI	ON ONLY IF APPLICAB	BLE. SE	E ABOVE*)									
DAY MONTH YEAR 1. DATE COVERAGE COMMENCED	4. CONTRACT HOLDER	DAY	DATE MONTH YEAR		AUTHORIZED							
3. DATE TERMINATED					(POSITION	UK IIILE)						

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL