

<b>PART 1 – DENTIST</b>	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.
LAST NAME _____ GIVEN NAME _____ ADDRESS _____ APT. _____ CITY _____ PROV. _____ POSTAL CODE _____	D E N T I S T  P H O N E N O. _____	_____ SIGNATURE OF SUBSCRIBER		

FOR DENTIST'S USE ONLY – FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION.  _____ OFFICE VERIFICATION/DENTIST'S SIGNATURE	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)
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DUPLICATE FORM 

DATE OF SERVICE			PROCEDURE CODE	INTL TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES	FOR CARRIER USE			
YR.	MO.	DAY							CLAIM NUMBER			

FOR CARRIER USE

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CLAIM NUMBER

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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.

 THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE. **TOTAL FEE SUBMITTED**
**INSTRUCTIONS FOR CLAIM SUBMISSION**

- HAVE THE ATTENDING DENTIST COMPLETE PART 1.
- COMPLETE PARTS 2 AND 3 BELOW ON EACH FORM SENT IN.
- ALL PARTS OF THIS FORM MUST BE COMPLETED IN FULL. IF NEEDED INFORMATION IS MISSING, THE FORM MAY BE RETURNED TO YOU.
- ALL CORRESPONDENCE, CLAIM FORMS, ETC. . . . MAIL TO: D.A. TOWNLEY

**PART 2 – MEMBER**

1. CONTROL NO./PLAN NO. \_\_\_\_\_ BRANCH NO. \_\_\_\_\_ ADDRESS OF MEMBER \_\_\_\_\_  
 EMPLOYER \_\_\_\_\_ MEMBER'S DATE OF BIRTH: YEAR \_\_\_\_\_ MONTH \_\_\_\_\_ DAY \_\_\_\_\_

2. NAME OF MEMBER \_\_\_\_\_ MEMBER'S SOCIAL INSURANCE NUMBER/IDENTITY 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 RELATED 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 \_\_\_\_\_