Capri Townley Benefit
Administrators Inc
Suite 100, 1500 Hardy Street
Kelowna, BC V1Y 8H2

STANDARD DENTAL CLAIM FORM

Canadian Dental Association

Canadian Life and Health Insurance Association Inc.

PART 1 DENTIST

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

SIGNATURE OF SUBSCRIBER

PATIENT

LAST NAME GIVEN NAME

ADDRESS APT.

CITY PROV. POSTAL CODE

DENTIST

PHONE-NO.

FOR DENTIST'S USE ONLY — FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION.

DUPLICATE FORM ☐

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.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION/DENTIST'S SIGNATURE

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

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

TOTAL FEE SUBMITTED

FOR CARRIER USE

CLAIM NUMBER

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 & ASSOCIATES LTD. IN ADVANCE FOR PREDETERMINATION OF BENEFITS. D.A. TOWNLEY & ASSOCIATES LTD. WILL INFORM YOU, BEFORE YOU UNDERTAKE TREATMENT, OF THE AMOUNT ALLOWED BY THE PLAN.

INSTRUCTIONS FOR CLAIM SUBMISSION

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

PART 2 — MEMBER

1. CONTROL NO./PLAN NO. _____ BRANCH NO. _____

ADDRESS OF MEMBER _____

EMPLOYER _____

MEMBER'S DATE OF BIRTH DAY _____ MONTH _____ YEAR _____

2. NAME OF MEMBER _____

MEMBER'S SOCIAL INSURANCE NUMBER/IDENTITY NUMBER _____

PART 3 — PATIENT INFORMATION

1. PATIENT RELATIONSHIP TO MEMBER _____

DATE OF BIRTH: DAY _____ MONTH _____ YEAR _____

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: DAY _____ MONTH _____

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 _____

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

MEMBER'S SIGNATURE: _____

DATE: DAY _____ MONTH _____ YEAR _____

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL