



RBC Insurance

P.O. BOX 1614, WINDSOR, ONTARIO N9A 0B9
ATTN: DENTAL DEPARTMENT
CUSTOMER SERVICE CENTRE 1-855-264-2174

DENTAL CLAIM FORM

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

Table with 9 columns: Date of Service (DAY MO YR), Procedure Code, Int'l Tooth Code, Tooth Surfaces, Provider's Fee, Laboratory Charges, Total Charges, Allowed Amount, Code. Includes a TOTAL FEE SUBMITTED row at the bottom.

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 RBC Life Identification Card for correct patient information). Incomplete or incorrect claim forms will be returned or rejected and will result in a delay in reimbursement.

PART 2 - EMPLOYEE/PLAN MEMBER

All claims must be submitted within 12 months of the date of service (unless otherwise stated in your benefit plan documentation).

Plan Member Name (Please Print), Plan Member ID, Plan Member 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, 2 Are any dental benefits or services provided under any other group insurance or dental plan, WSIB or Government plan?, 3 Is any treatment required as the result of an accident?, 4 If denture, crown or bridge, is this initial placement?, 5 Is any treatment required for orthodontic purposes?, 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, Signature of Plan Member, Date (Day Month Year)

All information recorded on this form is confidential. By signing this claim form and/or submitting actual receipts, I agree that the information provided on this form is complete and accurate. I understand that the information provided by me to RBC Life about myself and my dependents, will be used by RBC Life 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 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 insured.