OTIP RAEO®

OTIP Dental Claims
125 Northfield Drive West
PO Box 218
Waterloo ON N2J 3Z9

1.866.783.6847
www.otipservices.com

Standard Dental Claim Form

PART 1 - DENTIST (Please Print)

Unique No.	Spec.	Patient's Office Account No.

Patient – Last Name | First Name

Address | Apt.

City | Prov. | Postal Code

Telephone ( )

DENTIST

Telephone ( )

ASSIGNMENT OF BENEFITS:
I hereby assign my benefits payable from this claim to the named dentist and authorize payment directly to him/her.

Signature of Plan Member/Patient

For dentist's use only - 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 Plan Member/Patient
(Parent/Guardian)

Office Verification

Date of Service MM	DD	YYYY	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

Allowed Amount	Inc.	%	Patient's Share

Cheque No. | Date

Deductible | Patient Pays | Plan Pays

PLAN MEMBER - PLEASE COMPLETE PARTS 2, 3 & 4

PART 2 - PLAN MEMBER INFORMATION (Please Print)

Plan Number | Identification Number

Plan Member – Last Name | First Name

Address *(if different from above)* | Apt. No.

City/Town | Province | Postal Code

PART 3 - PATIENT INFORMATION (Please Print)

Patient Relationship: ☐ Plan Member (0)
☐ Spouse (1)
☐ Dependant (2) _____
Specify Relationship

Patient Date of Birth _____
(mm/dd/yyyy)

I certify that I, my spouse and/or my dependants of minor or major age ("Dependants"), have received all goods or services claimed and that the information provided for this claim is true and complete. **I authorize** OTIP and its insurer to collect, use, maintain and disclose personal information relevant to this claim ("Information") for the purposes of benefits plan administration, audit and the assessment, investigation and management of this claim ("Purposes"). **I am authorized** by my Dependants to disclose and receive their Information, for the Purposes. **I authorize** any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this Information with each other and with OTIP, its insurer and their reinsurers and/or service providers, for the Purposes. **I agree** a photocopy or electronic version of this authorization is valid. **I understand** that OTIP's Privacy Policy is available at www.otipservices.com or by request.

Signature of Plan Member/Patient _____ *(mm/dd/yyyy)*

Any Information provided to or collected by OTIP in accordance with this authorization, will be kept in a benefits health file. Access to your Information will be limited to:

- OTIP employees, representatives, OTIP's insurer and their reinsurers and service providers in the performance of their jobs;
- Persons to whom you have granted access; and
- Persons authorized by law.

You have the right to request access to the personal information in your file, and, where appropriate, to have any inaccurate information corrected.

PART 4 - ADDITIONAL INFORMATION

Plan Name _____

Home Telephone _____

Business Telephone _____

Is any of the above treatment required as a result of an accident? ☐ Yes ☐ No
If yes, give date and details of dental accident separately.

If yes, is the Workplace Safety and Insurance Board involved? ☐ Yes ☐ No

Do you have any other dental insurance coverage? ☐ Yes ☐ No
If yes, indicate insuring company name:

If denture, crown or bridge, is this the initial placement? ☐ Yes ☐ No
If no, give date of prior placement and reason for replacement.

Plan/Policy No. _____

Spouse's date of birth _____
(mm/dd/yyyy)

SUBMIT CLAIM TO:

OTIP Dental Claims
125 Northfield Drive West, PO Box 218
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