RADIANT ORTHODONTICS

Completing Your Standard Information Insurance Form

In order for you to receive reimbursement, the insurance company requires a brief description of the malocclusion and a breakdown of your payment schedule. This information is found on the Certified Specialist in Orthodontics Standard Information form. According to the insurance company, this form describes the "Treatment Plan".

It is important to complete this form accurately and attach appropriate receipts.

Below is a sample form. Follow the 10 steps on page 3 to put in the required information. The Group Policy Number and the Certificate Number (which may be listed as an ID number or employee number) are found on the insurance card that was provided to you by your employer.

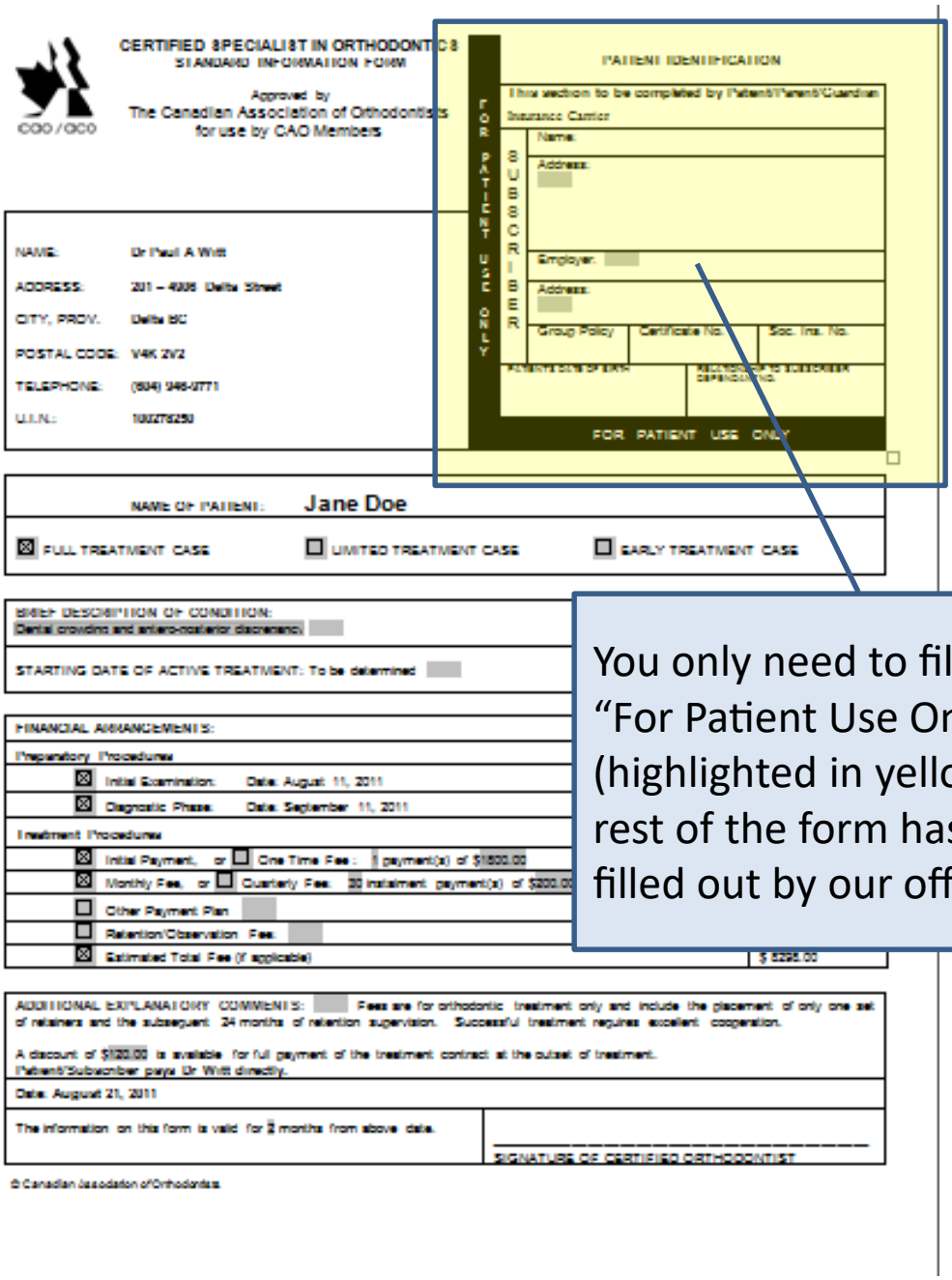
This form needs to be sent only once with the initial down payment receipt. The monthly payment receipts do not require this form to be attached.

In circumstances where there is dual coverage (i.e., the patient is covered under more than one insurance plan) you will need to send a copy of the form with your receipts to each insurance carrier. In the case of two different insurance carriers, the primary carrier is determined by the subscriber whose birthday falls first in the calendar year.

When submitting the insurance form and receipt to the secondary carrier, a copy of the remittance statement (i.e., receipt) from the primary insurance company must be included. In the case of both plans being with the same insurance carrier (e.g., both plans are with Manulife) the insurance forms and receipts can be sent at the same time.

If you have any further questions, please do not hesitate to call Radiant Orthodontics at 604.946.9771.

RADIANT ORTHODONTICS



CERTIFIED SPECIALIST IN ORTHODONTICS
STANDARD INFORMATION FORM

Approved by
The Canadian Association of Orthodontists
for use by CAO Members

FOR PATIENT USE ONLY

PATIENT IDENTIFICATION

This section to be completed by Patient/Parent/Guardian

Insurance Carrier

SUBSCRIBER

Name:

Address:

Employer:

Address:

Group Policy | Certificate No. | Soc. Ins. No.

FOR PATIENT USE ONLY

NAME: Dr Paul A Witt
ADDRESS: 201 – 4905 Delta Street
CITY, PROV.: Delta BC
POSTAL CODE: V4K 2V2
TELEPHONE: (604) 946-0771
U.I.N.: 1932778250

NAME OF PATIENT: Jane Doe

☒ FULL TREATMENT CASE ☐ LIMITED TREATMENT CASE ☐ EARLY TREATMENT CASE

BRIEF DESCRIPTION OF CONDITION:
Dental crowding and anterio-posterior discrepancy

STARTING DATE OF ACTIVE TREATMENT: To be determined

FINANCIAL ARRANGEMENTS:

Preparatory Procedures

☒ Initial Examination. Date: August 11, 2011
☒ Diagnostic Phase. Date: September 11, 2011

Treatment Procedures

☒ Initial Payment, or ☐ One Time Fee: 1 payment(s) of $1800.00
☒ Monthly Fee, or ☐ Quarterly Fee: 20 instalment payment(s) of $200.00
☐ Other Payment Plan
☐ Retention/Observation Fee.
☒ Estimated Total Fee (if applicable) $ 5200.00

ADDITIONAL EXPLANATORY COMMENTS: Fees are for orthodontic treatment only and include the placement of only one set of retainers and the subsequent 24 months of retention supervision. Successful treatment requires excellent cooperation.

A discount of $120.00 is available for full payment of the treatment contract at the outset of treatment.
Patient/Subscriber pays Dr Witt directly.

Date: August 21, 2011

The information on this form is valid for 2 months from above date.

SIGNATURE OF CERTIFIED ORTHODONTIST

© Canadian Association of Orthodontists

You only need to fill in the "For Patient Use Only" box (highlighted in yellow). The rest of the form has been filled out by our office.

RADIANT ORTHODONTICS

1. Print the name of your Insurance Company here. For example: Great West Life, Pacific Blue Cross, Sun Life.

2. Print the name of the **insurance policy holder** here. This may or may not be the patient. For child patients, it is usually a parent/guardian, but in the case of adult patients it may be the patient or his/her spouse.

3. Print the address of the **insurance policy holder** (named in step 2) here.

4. Print the **employer** of the insurance policy holder (named in step 2) here.

5. Print the address of the employer (named in step 4) here.

6. Print the Group Policy Number from the insurance policy holder's insurance card here.

7. Print the Certificate Number from the insurance policy holder's insurance card here. It may be listed as an ID number or employee number on the card.

8. Print the **insurance policy holder**'s SIN here.

9. Print the relationship of the patient to the **insurance policy holder** here. If the patient is the insurance policy holder, print "Self". Otherwise, describe the relationship as "Father", "Mother", "Husband", "Wife", etc. Also include the patient's **Dependent Number** as listed on the card (if applicable; some companies do not require this).

10. Print the **patient**'s date of birth here.

FOR PATIENT USE ONLY

PATIENT IDENTIFICATION

This section to be completed by Patient/Parent/Guardian

Insurance Carrier

SUBSCRIBER

Name:

Address:

Employer:

Address:

Group Policy	Certificate No.	Soc. Ins. No.

PATIENT'S DATE OF BIRTH	RELATIONSHIP TO SUBSCRIBER DEPENDANT NO.

FOR PATIENT USE ONLY