OTIP RAEO

Reset

Standard Dental Claim

SECTION 1: DENTIST INFORMATION

PATIENT

Last Name	Given Name	Unique No.	Spec	Patient's Office Acct. No.

Address Apt.

City Prov. Postal Code

DENTIST

Phone No.

For Dentist's use only - For additional information, diagnosis, procedures, or special consideration.

I hereby assign my benefits payable from this claim to the named Dentist and authorize payment directly to him/her.

SIGNATURE OF PLAN MEMBER ▶

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) ▶

☐ Duplicate Form

Office verification

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: $

☐ **CHECK HERE IF TREATMENT PLAN**

When a proposed course of treatment is expected to cost more than $500, a treatment plan must be filed with OTIP Benefits Services. You will be advised of the benefits payable under your plan before treatment begins. Pre-treatment x-rays are required for some procedures (e.g. crowns and bridges).

SECTION 2: MEMBER BASIC PERSONAL INFORMATION

Plan Member Name (First, Middle Initial and Last)

OTIP Identification Number	Plan Number	Date of Birth *(mm/dd/yyyy)*

Plan Sponsor	Email Address

Direct Deposit

Receive your claim payments faster with direct deposit and enjoy the convenience of seeing your claim statements online.

Visit www.otip.com and log in. Once you have logged in to the Plan Member Secure Site (also known as 'My Claims'), choose **My profile** from the top navigation, then **Update banking information.** First-time users, you will need to complete registration.

SECTION 3: PATIENT INFORMATION

1. Patient: Relationship to Plan Member_____ Date of Birth *(mm/dd/yyyy)*_____

   If Child, indicate: ☐ Student ☐ Handicapped If Student, Indicate School _____

2. Are any dental benefits or services provided under any other group insurance or dental plan? ☐ Yes ☐ No
   Any type of workers' compensation board or government plan?

   Plan Contract Number _____ Name of Insurance Company _____

   Spouse Date of Birth *(mm/dd/yyyy)* _____

3. Is any treatment required as the result of an accident? If "**Yes**", give date and details separately. ☐ Yes ☐ No

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

5. Is any treatment required for orthodontic purposes? ☐ Yes ☐ No

SECTION 4: CERTIFICATION AND AUTHORIZATION

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 the group benefits insurance carrier ("Insurer") that provides my benefits coverage 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, plan sponsor, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this Information with each other and with OTIP, the Insurer and their reinsurers and/or service providers, for the Purposes. I authorize the use of my OTIP ID number for the purposes of identification and administration. I agree a photocopy or electronic version of this authorization is valid. I acknowledge that more specific details regarding how and why OTIP and the Insurer collect, use, maintain, and disclose my personal information can be found in OTIP's Privacy Policy available at www.otip.com, or the Insurer's Privacy Policy available at www.manulife.com, or by request.

Signature of Plan Member **Date** *(mm/dd/yyyy)*

Any Information provided to or collected by the Insurer in accordance with this authorization, will be kept in a benefits health file.

Access to your Information will be limited to:

- The 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.

SECTION 5: MAILING INSTRUCTIONS

Please mail your completed claim form and receipts to the address below.

OTIP Dental Claims
PO Box 280
Waterloo ON N2J 4A4

QUESTIONS?

OTIP Benefits Services
1-866-783-6847