Completing Your Standard Information Insurance Form

In order for you to receive reimbursement, the insurance company (insurer) 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" that is provided to you by our office. This form describes the "Treatment Plan" and the associated schedule of fees to the insurer.

It is important that you complete the PATIENT IDENTIFICATION "FOR PATIENT USE ONLY" portion of this form accurately and attach appropriate receipts.

Below is an example of the 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 called an ID Number or Employee Number on your policy) are found on the insurance card provided to you by your employer.

This Standard Information form needs to be sent only once to the insurer at the time that the initial down payment is made, or alternatively, prior to treatment if you are requesting pre-treatment authorization. The monthly payment receipts do not require this form to be attached. However, you may need to complete and attach a "dental" claim form (provided by the insurer through your employer) to the receipts for identification purposes.

In circumstances with dual coverage (i.e. patient is covered by more than one insurance plan), you will need to send one copy of the Form with your receipts to each insurer. In the case of two different insurers, the insurer of the subscriber whose birthday falls first in the calendar year is deemed to be the "primary" carrier. To submit the insurance form and receipt to the "secondary" carrier, a copy of the remittance statement (i.e. proof of payment) from the primary insurer must be included. In other words, you must have received payment from the primary insurer before submitting your claim to the secondary insurer. If both plans are with the same insurer (e.g. both plans are with Manulife), insurance forms and receipts can be sent at the same time.

If you have any questions, please call Radiant Orthodontics at 604.946.9771.

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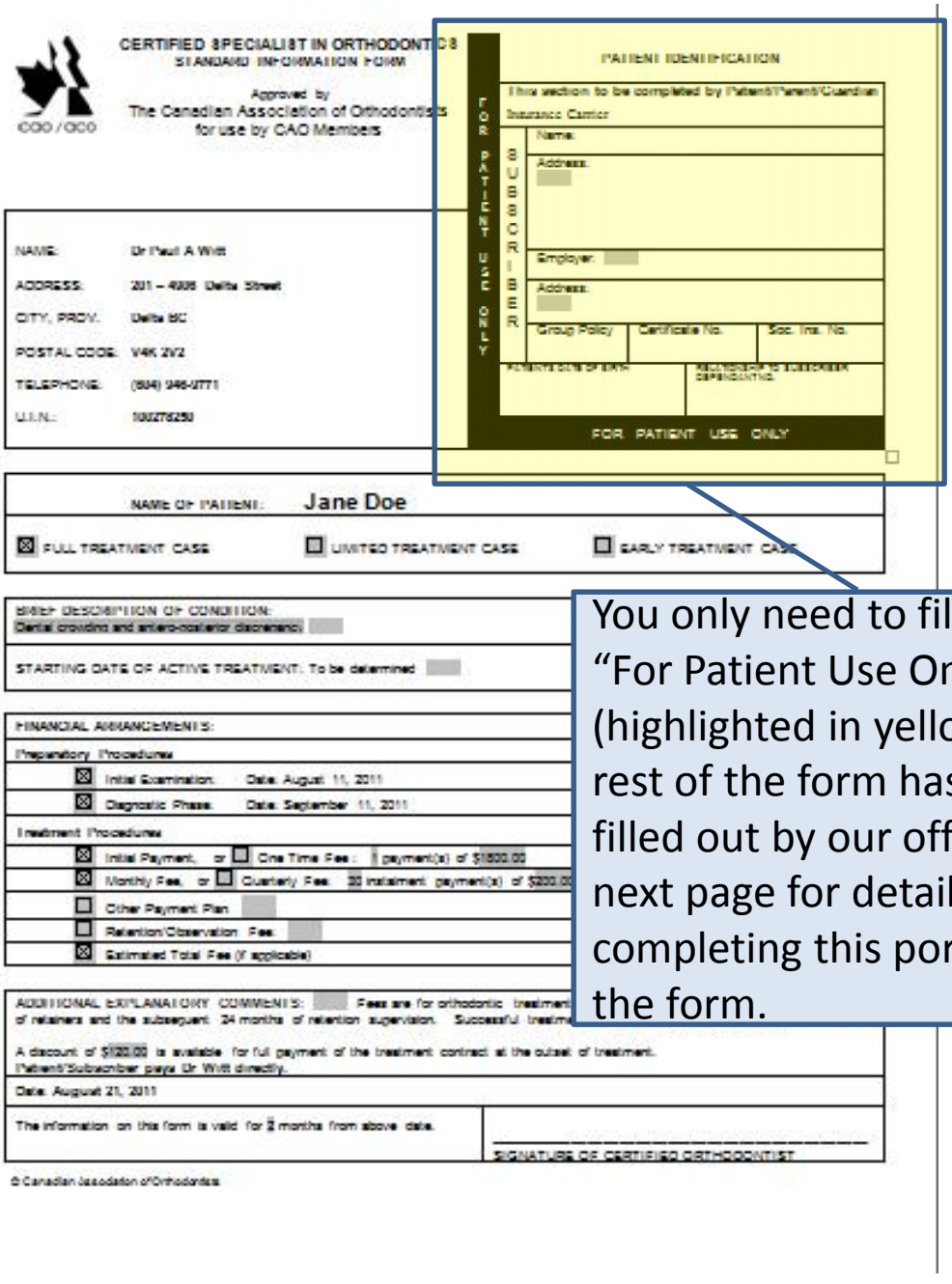
ORTHODONTICS



CERTIFIED SPECIALIST IN ORTHODONTICS
STANDARD INFORMATION FORM

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

PATIENT IDENTIFICATION

This section to be completed by Patient/Parent/Guardian

FOR PATIENT USE ONLY

Insurance Carrier

SUBSCRIBER

Name:

Address:

Employer:

Address:

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

Patient's Date of Birth | Relationship to Subscriber (Dependant)

FOR PATIENT USE ONLY

NAME: Dr Paul A Witt
ADDRESS: 201 – 4936 Delta Street
CITY, PROV.: Delta BC
POSTAL CODE: V4K 2V2
TELEPHONE: (604) 946-0771
U.I.N.: 100276250

NAME OF PATIENT: Jane Doe

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

BRIEF DESCRIPTION OF CONDITION:
Dental crowding and antero-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 payment(s) of $1800.00
☒ Monthly Fee or ☐ Quarterly Fee 22 instalment payment(s) of $200.00
☐ Other Payment Plan
☐ Retention/Observation Fee
☒ Estimated Total Fee (if applicable)

ADDITIONAL EXPLANATORY COMMENTS: Fees are for orthodontic treatment
of retainers and the subsequent 24 months of retention supervision. Successful treatme

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. See next page for details on completing this portion of the form.

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

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.

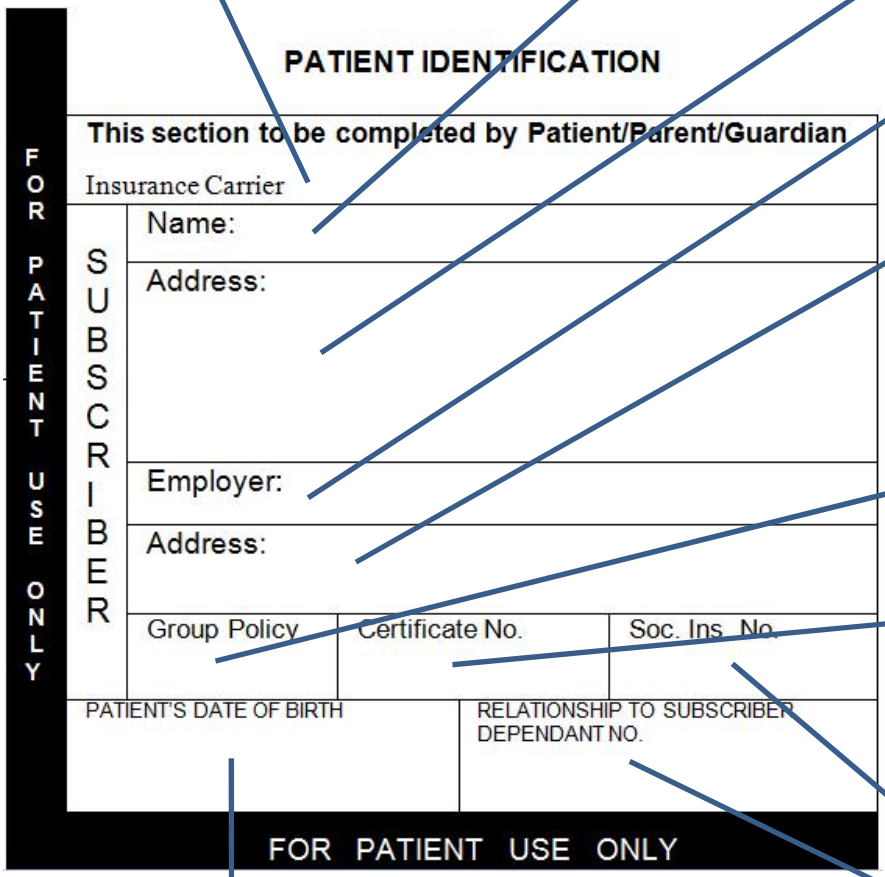
4. Print the **Employer of the Insurance Policy Holder** (named in step 2) here.

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.



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

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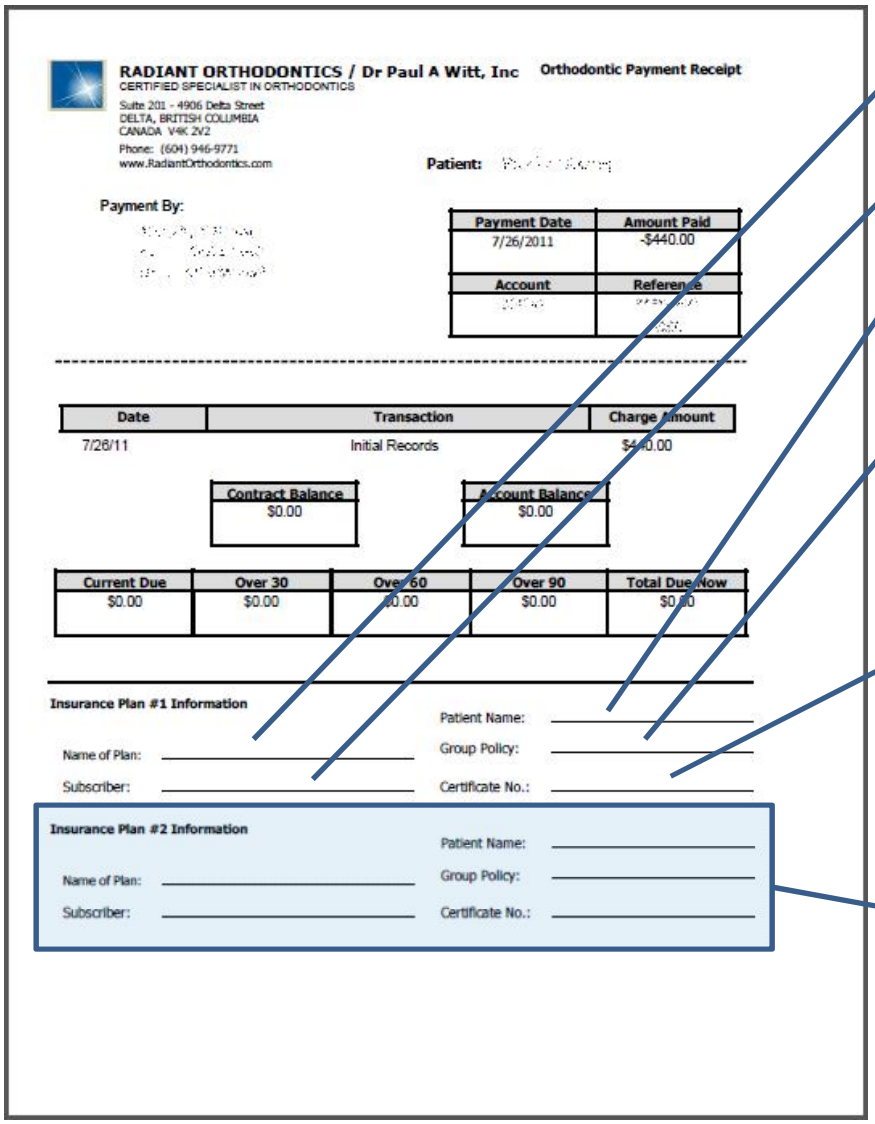
Preparing Your Receipt for an Insurance Claim Submission

Every time you make a payment, you will need to submit the receipt. Receipts for initial exams, initial records, and down payments are submitted with the "Certified Specialist in Orthodontics Standard Information Form". Receipts for recurring payments are submitted on their own. To safeguard against confusion during the claims process, we recommend that you complete the bottom portion of *every* receipt (as depicted below) before submitting it.

If you have any questions, please call Radiant Orthodontics at 604.946.9771.



RADIANT ORTHODONTICS / Dr Paul A Witt, Inc Orthodontic Payment Receipt
CERTIFIED SPECIALIST IN ORTHODONTICS
Suite 201 - 4906 Delta Street
DELTA, BRITISH COLUMBIA
CANADA V4K 2V2
Phone: (604) 946-9771
www.RadiantOrthodontics.com

Patient:

Payment By:

Payment Date	Amount Paid
7/26/2011	-$440.00
Account	Reference

Date	Transaction	Charge Amount
7/26/11	Initial Records	$440.00

Contract Balance	Account Balance
$0.00	$0.00

Current Due	Over 30	Over 60	Over 90	Total Due Now
$0.00	$0.00	$0.00	$0.00	$0.00

Insurance Plan #1 Information

Name of Plan: _____ Patient Name: _____
Subscriber: _____ Group Policy: _____
Certificate No.: _____

Insurance Plan #2 Information

Name of Plan: _____ Patient Name: _____
Subscriber: _____ Group Policy: _____
Certificate No.: _____

1. Print the **name of your Insurance Company** here.

2. Print the **name of the Insurance Policy Holder** here.

3. Print the name of the **Patient** here.

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

5. 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**.

6. If there is a second insurance policy, repeat steps 1-5 here. You will need to send a second copy of this receipt to this insurance provider.