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| PART 1 — DENTIST | | UNIQUE NO. | SPEC. | PATIENT'S OFFICE ACCOUNT NO. | I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER. _____ SIGNATURE OF SUBSCRIBER |
| P A T I E N T | LAST NAME _____ GIVEN NAME _____ ADDRESS _____ APT. _____ CITY _____ PROV. _____ POSTAL CODE _____ | D E N T I S T | PHONE NO. _____ | | |

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| FOR DENTIST'S USE ONLY — FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION. _____ OFFICE VERIFICATION/DENTIST'S SIGNATURE | 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 THE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO D.A. TOWNLEY & ASSOCIATES LTD., MY INSURER, AND MY POLICYHOLDER. THE INFORMATION RELEASED THROUGH THIS AUTHORIZATION IS TO BE USED FOR CLAIMS ADJUDICATION PURPOSES AND STATISTICAL ANALYSIS. _____ SIGNATURE OF PATIENT (PARENT/GUARDIAN) |
|---|---|

| DATE OF SERVICE | | | PROCEDURE CODE | INTL TOOTH CODE | TOOTH SURFACES | DENTIST'S FEE | LABORATORY CHARGE | TOTAL CHARGES | FOR CARRIER USE | |
|-----------------|-----|-----|----------------|-----------------|----------------|---------------|-------------------|---------------|--|--|
| YR. | MO. | DAY | | | | | | | CLAIM NUMBER | |
| | | | | | | | | | IF YOUR DENTIST RECOMMENDS A COURSE OF TREATMENT INVOLVING FEES OF \$600.00 OR MORE, HIS/HER TREATMENT PLAN MAY BE SUBMITTED TO D.A. TOWNLEY & ASSOCIATES LTD. IN ADVANCE FOR PREDETERMINATION OF BENEFITS. D.A. TOWNLEY & ASSOCIATES LTD. WILL INFORM YOU, BEFORE YOU UNDERTAKE TREATMENT, OF THE AMOUNT ALLOWED BY THE PLAN. | |
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THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE. **TOTAL FEE SUBMITTED**

INSTRUCTIONS FOR CLAIM SUBMISSION

1. HAVE THE ATTENDING DENTIST COMPLETE PART 1. 3. ALL PARTS OF THIS FORM MUST BE COMPLETED IN FULL. IF NEEDED INFORMATION IS MISSING, THE FORM MAY BE RETURNED TO YOU.
 2. COMPLETE PARTS 2 AND 3 BELOW ON EACH FORM SENT IN. 4. ALL CORRESPONDENCE, CLAIM FORMS, ETC. . . . MAIL TO: D.A. TOWNLEY & ASSOCIATES LTD.

PART 2 — MEMBER

1. CONTROL NO./PLAN NO. _____ BRANCH NO. _____ ADDRESS OF MEMBER _____
 EMPLOYER _____ MEMBER'S DATE OF BIRTH: YEAR _____ MONTH _____ DAY _____
 2. NAME OF MEMBER _____ MEMBER'S I.D./CERTIFICATE NUMBER _____

PART 3 — PATIENT INFORMATION

1. PATIENT: RELATIONSHIP TO MEMBER _____ DATE OF BIRTH: YEAR _____ MONTH _____ DAY _____
 2. IF CLAIM IS FOR DEPENDENT CHILD, IS THAT CHILD
 HANDICAPPED? YES NO MARRIED? YES NO
 A FULL TIME STUDENT? YES NO EMPLOYED? YES NO
 3. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER PLAN OF INSURANCE OR DENTAL SERVICES: YES NO IF "YES," PROVIDE:
 POLICY NUMBER: _____
 NAME OF INSURER: _____
 SPOUSE'S NAME: _____
 SPOUSE'S DATE OF BIRTH: YEAR _____ MONTH _____ DAY _____
 4. IS ANY OF THE ABOVE WORK FOR ORTHODONTIC PURPOSES? YES NO
 5. A) IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? YES NO
 GIVE DATE AND DETAILS _____
 B) IS CLAIM BEING MADE FOR WORKERS' COMPENSATION BENEFITS? YES NO
 6. IF THE TREATMENT INVOLVES THE PLACEMENT OF A BRIDGE, DENTURE OR CROWN:
 A) IS THIS THE INITIAL PLACEMENT?
 UPPER YES NO LOWER YES NO
 B) IF "NO" GIVE THE DATE OF PRIOR PLACEMENT AND THE REASON FOR REPLACEMENT _____
 C) DATE OF EXTRACTIONS _____
 I UNDERSTAND THAT D.A. TOWNLEY & ASSOCIATES LTD. COLLECTS PERSONAL INFORMATION TO ASSESS ELIGIBILITY FOR BENEFITS; TO DETERMINE AND ADJUDICATE BENEFITS, TO DETERMINE THE COST AND FINANCIALLY MANAGE THESE BENEFITS, AS WELL AS TO MEET REGULATORY OR CONTRACTUAL REQUIREMENTS RELATING TO SUCH BENEFITS AND RELATED SERVICES PROVIDED. I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO D.A. TOWNLEY & ASSOCIATES LTD., MY INSURER, AND MY POLICYHOLDER AND CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE, TO THE BEST OF MY KNOWLEDGE. THE INFORMATION RELEASED THROUGH THIS AUTHORIZATION WILL BE USED FOR CLAIMS ADJUDICATION PURPOSES AND STATISTICAL ANALYSIS.
 MEMBER'S SIGNATURE: _____
 DATE: YEAR _____ MONTH _____ DAY _____