Electrical Industry Insurance Benefit Trust Fund of Alberta
#200, 4224 – 93 Street, Edmonton, Alberta T6E 5P5
Phone: (780) 465-2882 Toll Free 1-800-268-3649
Facsimile: (780) 465-0808
e-mail: claims@ebfa.ca

DENTAL - Direct Reimbursement Form

Part 1 – Dentist Unique No. Spec. Patient's Office Account No.

PATIENT:
LAST NAME GIVEN NAME
ADDRESS
ADDRESS
CITY PROV. POSTAL CODE

DENTIST:
PHONE NUMBER:

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.

SIGNATURE OF PLAN MEMBER

FOR DENTIST'S USE ONLY – FOR 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 Patient (Parent/Guardian)

Office Verification

Date of Service DAY	MO.	YR.	Procedure Code	Int Tth 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

INSTRUCTIONS

Part 1 to be completed by Dentist.

Part 2 to be completed by Plan Member.

Please use one form for each patient.

Oral exams, cleaning, and bite-wing x-rays will only be eligible once per calendar year, per person.

Part 2 – To be completed by Plan Member

Policy Number: 6012
Plan Member's EBFA Stakeholder Number: _____

1. Patient: Relationship to Employee_____ Date of Birth:_____
   If Child, indicate ☐ Full time student ☐ Handicapped
   Date enrolled_____ Date Completed_____
2. Are there any dental benefits or services provided under any other group Insurance, gov. agency or dental plan? ☐ No ☐ Yes
   ☐ Health Only ☐ Dental Only ☐ Both Policy Number_____
   Name of Insurance Agency _____
   If coordination of benefits no longer applies, termination date _____
   If claim is for a dependent child, please indicate spouse's date of birth _____
3. Is treatment for orthodontic purposes? ☐ No ☐ Yes
4. Is treatment for TMJ purposes? ☐ No ☐ Yes
5. Is treatment for cosmetic purposes? ☐ No ☐ Yes
6. If denture, crown or bridge, is this an initial placement? ☐ No ☐ Yes
   Provide teeth numbers the appliance is replacing _____
7. For the appliance, provide the dates the teeth were extracted _____
8. If replacement appliance, provide date of prior placement and reason for replacement: _____
9. Is treatment a result of an occupational illness or injury, or otherwise related to employment? ☐ No ☐ Yes
10. I authorize release of the information contained in this claim form to the Insurer/Board of Trustees, its authorized representative or consultant for purposes of settlement of this claim.

Plan Member's Name: _____ (Please Print)
Address: _____
Telephone Number: _____
Date: _____/_____/_____ Day Month Year

Signature of Plan Member