Allendale Centre East
Suite 301, 6104-104 Street NW
Edmonton | Alberta | T6H 2K7
Phone: 1-877-431-4786
www.asebp.ca

DENTAL CARE CLAIM

Policy # 19930

PART 1 DENTIST

Unique No.	Spec	Patient's Office Account No.

Patient's name _____

Mailing address _____

Postal code: _____ Phone no.: _____

Dentist's information

Phone no. _____

I, the covered member of the Alberta School Employee Benefit Plan, hereby assign benefits payable for this claim to the named dentist and authorize payment directly to him/her/them.

_____
Covered member's signature

FOR DENTIST USE ONLY: Additional information, diagnosis, procedures or special consideration

Duplicate form ☐

I acknowledge that the total fee of $ _____ is accurate and has been charged to me for services rendered.

_____
Patient signature (Parent/Guardian)

Office verification

Date of service Day	Mo.	Yr.	Procedure code	Tooth code	Tooth surfaces	Dentist fee	Laboratory charges	Total charges

This is an accurate statement of services performed and the total fee due and payable.

TOTAL FEE SUBMITTED

DENTAL ACCIDENT ONLY

Is treatment required as a result of an accident?

☐ NO ☐ YES If yes, please complete the following:

Date of accident: _____

Teeth injured: _____

Details of accident: _____

PART 2 EMPLOYEE STATEMENT *(See back for specific instructions)*

1. Employer _____
2. Employee name: _____ ID #: _____

   Employee address: _____ Employee's date of birth: YYYY _____ MM _____ DD _____
3. Patient's name: _____ Relationship to employee: _____

   Patient's date of birth: YYYY _____ MM _____ DD _____
4. For crown, bridge or dentures: Is this an initial placement? ☐ NO ☐ YES

   If no, indicate date of insertion of existing crown, bridge or denture. YYYY _____ MM _____ DD _____
5. Is treatment required for orthodontic purposes? ☐ NO ☐ YES

COORDINATION OF BENEFITS

Are you and/or your spouse/partner covered under another insurance plan? ☐ NO ☐ YES Is your child covered under another insurance plan? ☐ NO ☐ YES

If **yes**, ☐ ASEBP Plan ID # _____ Spouse/partner or child's date of birth: YYYY _____ MM _____ DD _____

OR ☐ Name of other insurance company: _____ Policy # _____ ID# _____

CONSENT FOR THE COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

I understand that the personal information contained in this form and supporting documentation as well as other personal information held by the Alberta School Employee Benefit Plan (ASEBP) is used to determine eligibility of this benefit, verify, assess and pay claims and administer my group benefit plan. By submitting this claim form, I am requesting payment for the listed expenses based on my group benefits plan guidelines and understand that these expenses may not be covered or may exceed my plan benefits and that I am financially responsible to my dentist for the entire treatment. It may be necessary for the ASEBP to disclose some or all of the personal information contained herein to third party service providers for these purposes. Where third party service providers are retained, appropriate contracts are in place to protect personal information.

I understand why the information is required and am aware of the risks and benefits of providing this information. I consent to the collection, use and disclosure of my personal information for the purposes identified above. I understand that I may revoke my consent at any time and acknowledge that doing so will affect my and my dependants' eligibility to receive group benefits.

I understand that by virtue of the provisions of the *Personal Information Protection Act* of Alberta, my dependants are deemed to consent to the collection, use and disclosure of their personal information for the purpose of enrolment in and coverage under the group benefit plans, through me as the applicant.

I agree to the above and declare that my statements in this expense reimbursement request are complete, accurate and true.

Date: _____ Signature: _____

Please turn over ☞

DENTAL CARE CLAIM *FAXED CLAIMS ARE NOT ACCEPTED*

The reimbursement is applied to the lesser of the actual cost of the expense or the applicable maximum fee level of the current *ASEBP Dental Benefit List*.

PLAN DESCRIPTION

Plan 1	Provides 100% reimbursement of basic treatment to a maximum benefit of $1,500 per person per calendar year.
Plan 2	Provides 100% reimbursement of basic treatment and 50% reimbursement of major treatment to a combined maximum benefit of $2,500 per person per calendar year.
Plan 3	Provides 100% reimbursement of basic treatment and 60% reimbursement of major treatment. The maximum for major treatments is $2,500 per person per calendar year. Provides 60% reimbursement of orthodontic treatment to a lifetime maximum of $3,000.
Plan 4	Provides 50% reimbursement of basic treatment and 50% of major treatment to a combined maximum benefit of $1,000 per person per calendar year. There is an annual family deductible of $50.

Dental Estimates:
(Predetermination)

For all claims with the exception of orthodontics:
A dental estimate is not required for claim payment under the Alberta School Employee Benefit Plan (ASEBP). It will be supplied to you if your dentist submits the request using one of the following methods:

- A paper request where the proposed dental treatment plans are **over** $500
- An electronic request where the proposed dental treatment plans are **under** $500

For orthodontics claims:
ASEBP requires the submission of a predetermination after your initial examination and diagnostics for orthodontics prior to treatment.

X-rays must accompany claims for major services on anterior teeth.

To ensure that your claim is processed promptly, please read the following instructions. Your claim may be returned if any of the required information is missing or incomplete.

1. Have your dentist complete the statement in Part 1
2. Covered member must complete the statement on Part 2
   Note: i) A separate form is required for each person for whom a claim is being made
   ii) Additional forms are available from your employer or ASEBP's website (www.asebp.ab.ca)
   iii) The form must be signed by the covered member

ASSIGNMENT OF BENEFITS
ASEBP has the right to choose which practitioners they will accept assignment of benefit arrangements from and the benefit categories for which assignment of benefit arrangements can be made.

CLAIM SUBMISSION DEADLINE
Claims must be received by ASEBP within **18 months** of the date the expense is incurred. Claims **more than** 18 months old will not be paid. **Faxed claims are not accepted.**

Mail completed claim forms to:

Alberta School Employee Benefit Plan
Allendale Centre East
Suite 301, 6104-104 Street NW
Edmonton AB T6H 2K7