INSTRUCTIONS

You must provide all information requested; incomplete claim forms cannot be processed.

IMPORTANT POINTS TO REMEMBER WHEN COMPLETING YOUR CLAIM:

1. Your Insurer must receive notice of your accident within 30 days of the accident date, and receive claim documentation within 90 days.

2. ALL claims must be submitted with itemized statements and paid receipts (originals are required if there is no other coverage available), which indicate:
   patient's name
   type of purchase or service
   date of each purchase or service
   amount charged for each purchase or service

3. A physician statement confirming diagnosis and recommended treatments is required if you are claiming other than dental or ambulance expense.

4. Only claims in excess of the deductible, specified in your plan details, will be considered for payment up to your maximum benefits.

5. Expenses eligible under any other health care plan(s) must be submitted to that plan(s). Your sports accident policy will pay only the amount of expenses that are not eligible with any other insurer.

• IF YOU ARE CLAIMING ANY OF THE BENEFITS LISTED BELOW, YOU MUST INCLUDE THE FOLLOWING INFORMATION WITH YOUR CLAIM:
(Please check your plan details for the conditions under which these benefits are eligible. You must have required and received medical/dental treatment commencing within 30 days of the accident date.)

• FOR BENEFITS NOT LISTED BELOW, PLEASE CONTACT THE INSURER FOR CLAIMS PROCEDURE

A. PRESCRIBED DRUGS -
   name of medication or
   drug -date of purchase
   – amount charged

B. SERVICES OF PHYSIOTHERAPIST,
   CHIROPRACTOR, OSTEOPATH
   – physician referral
   -type of service
   -date of each treatment
   -amount charged for each treatment
   -dates of treatments paid by Provincial Medical Plan; if private fees apply, confirming coverage has been exhausted

C. HOSPITAL ROOM ACCOMMODATION
   -not an eligible expense

D. AMBULANCE (Emergency to Hospital only) -date of service
   -places ambulance taken from and to
   – amount charged

E. VISION CARE
   -if your injury received medical treatment and resulted in the loss or damage of eyewear, or the requirement of eyewear due to accident
   -an explanation must be submitted with your receipt to claim the limited benefit

F. SCHEDULED FRACTURE INDEMNITY
   -if your injury results in any of the fractures or dislocations listed on the policy schedule, there may be an amount payable to you; not more than one amount (the largest) is payable.
   -a statement completed by the licensed physician or surgeon confirming the fracture/dislocation

G. MEDICAL BRACES
   -a letter from the licensed physician or surgeon indicating the diagnosis, the specific medical necessity for prescribing the brace and the type of brace prescribed, must be submitted with your receipt
   -medical braces required primarily for sporting type activities are not covered

H. DENTAL ACCIDENTS -exact date of accident -breakdown of services performed
   -circumstances surrounding the accident
   – is there other dental coverage? Enclose details -confirmation that treatments only relate to the accident -provide other insurer's explanation
   -are further treatments estimated?

I. SERVICES AVAILABLE WITHIN THE PROVINCIAL PLAN
   -your Sports Accident Policy does not make payment for any service or treatment that is available within the provincial plan, whether there is enrollment in the provincial plan or not.

YOUR SPORTS ACCIDENT POLICY MAY INCLUDE A DEDUCTIBLE AND/OR A PERCENTAGE OF REIMBURSEMENT. (Example: $100 deductible or $30 per treatment up to $300 per accident.) IF IN DOUBT, CHECK YOUR PLAN DETAILS.

ALBERTA LACROSSE ASSOCIATION
DENTAL CLAIM FORM

Claim forms must be mailed to the ALA for verification of the members coverage prior to the Insurers approval: ALA mailing address: 11759 Groat Road, Edmonton Alberta T5M 3K6

PART 1 DENTIST

Dentist's Name	Patient's Last Name	Given Names
Address	Address	Apt.
City, Province	City, Province	
Postal Code	Postal Code	
Telephone		

Date of Service Day	Mo	Year	int. Tooth Code	Procedure Code	Tooth Surfaces	Laboratory Charge	Dentists Fee	Total Charge

FOR PLAN ADMINISTRATOR USE ONLY:

Please Note - Under the terms of the Policy, this report must be forwarded to the Company within 90 days of the date of the accident. Your co-operation will be appreciated.

This is an accurate statement of Services performed and fees charged: E. & E. O.

Total Submitted Fees

CLAIM APPROVED:

DD/MM/YYYY Adjuster/Assessor

Dentist's Signature: _____ Date: _____
Day Month Year

APPROVAL
ALBERTA LACROSSE ASSOCIATION

FOR DENTIST'S USE ONLY.

For additional information Re: diagnosis, procedures, or complications, and special considerations.

The claimant is a member in good standing of the ALA?

Yes ☐ No ☐

The claim occurred at an ALA sanctioned event/activity?

Yes ☐ No ☐

exceed my policy benefits. I understand that I am financially responsible to my dentist for the entire cost of the treatment. I authorize release of the information contained in this claim form to my Insuring company or its agents.

_____
Signature of Patient (or Parent/Guardian)

from this claim to the above named dentist and authorize payment directly to him.

_____
Signature of Subscriber

Approved by Alberta Lacrosse Association:

Name & Title: _____

Signature: _____

PART 2. DENTIST'S SUPPLEMENTARY REPORT

1. Description of Damage

2. Is further treatment indicated? Yes ☐ No ☐ If "Yes" please indicate:

Int. Tooth Code		Treatment Indicated — use procedure code if possible	Est. Date - Treatment Day	Mo.	Yr.

3. Describe further potential problems and indicate time frame.

Date: Day Month Year

Dentist's Signature

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL