Confidence with every smile

HANNAH ORTHODONTICS

INSURANCE VERIFICATION & AUTHORIZATION FORM

We will be happy to verify and file your insurance for your orthodontic treatment. Please complete the following information and if possible, provide us with a copy of an insurance card. Also, signing the authorization below gives us permission to obtain insurance information and file your claim.

Today's Date_____

DENTAL INSURANCE INFORMATION

Patient's Name _____
Last First Middle

Birthdate_____

Subscriber's Name _____
Last First Middle

Birthdate_____

Relationship to Patient: SELF SPOUSE MOTHER FATHER STEP PARENT *(circle one)*

Subscriber's Employer _____

Insurance Company _____

Insurance Co. Address _____

_____Insurance Co. Phone_____

Group #_____ or Union Local # _____

*ID #_____ Effective Date_____

* This is usually the insured's Social Security # or they may have assigned you a "unique" identifier. If it is your Social Security # and it is "truncated" on your card, we still need the full number to file. Thank You.

If you have a second insurance company please complete a separate form for that company.

If you are filling out this form because you have new insurance from what we have on file for you, is this because of a job change or did your employer just change insurance carriers? Circle one please:

NEW JOB or SAME EMPLOYER/New Carrier Information

AUTHORIZATIONS

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

Parent/Guardian Signature _____ Date_____

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

Subscriber Signature_____ Date_____

TC/BUSINESS OFFICE USE ONLY

Benefit information

LTM_____ Available benefit remaining_____

Age limits_____ Deductible_____

Payment schedule: Auto / Quarterly Waiting period: Yes / No