

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 <i>(circle one)</i>						
Subscriber's Employer _____						
Insurance Company _____						
Insurance Co. Address _____						
_____ Insurance Co. Phone _____						
Group # _____ or Union Local # _____						
*ID # _____ Effective Date _____						
<small>* 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.</small>						

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