DENTAL INSURANCE INFORMATION

Patients Name_____________________________ Patient Date of Birth ______________________________

Relationship to subscriber ____self ____spouse ____child ____other

Sex ____Male ____Female

Subscribers Name ___________________________ Subscribers Date of Birth ________________________

Subscribers Address ____

City ______________________ State ______ Zip ________________________________

Subscribers SS# / ID# ____

Employer Name & Phone Number ____

Insurance Name & Phone Number____

Insurances Address____

I authorize release of any informations relating to this claim. I certify that the above information is correct and authorize payment directly to the dentist.

____

Subscriber Signature Date

==

Below is to be completed by dental office only

VERIFICATION OF INSURANCE

____ New ___ Adding ____Replacing: ______________

Date: ____________ Spoke to: ______________

Patient Name: ___________________________ Effective Date: ___________ Group# ______

Ins Co Name: ____________________ Phone #: ____________________ Payor ID# ________

Employer: ______________________ ID: ____________________ Orthodontic Coverage: Y / N

Adult Coverage: Y / N

LTM: _____________ LTM used to date: ___________ Records: included or separate in LTM

** if ext's are indicated are

Waiting period: Y / N Deductible: Y / N Pays at _______ % they deducted from general/ortho

Payments are made: Monthly Quarterly Semi Annually Annually All at once

Submit claims: One time only Monthly Quarterly Semi Annually Annually

Mail claims to: ______________________ RDS? D0330 (PAN)_____ D0350 (PICS) _________

__________________________________ D0340 (CEPH)________ D0470 (SMS) __________

(if multiple policies) non-duplicating clause? Y / N WIP claims? Y/N