

Insurance Authorization

Insurance Company: _____

Insurance Address: _____

City/State/Zip _____

Insurance Company Phone: _____ Group/Policy _____

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's DOB: _____ SS# _____

Subscriber's Employer: _____

Does this policy cover Orthodontics? Yes No

Authorizations:

1. Patient or Parent/Guardian's Authorization for Disclosure of Records for the purpose of obtaining insurance payments.

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 benefits 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 insurance to carry out payment activities in connection with this claim.

Signature of Patient or Parent/Guardian

Date

2. Subscriber's (Policyholder's) Authorization for payment of benefits.

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

Signature of Patient or Parent/Guardian

Date

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Insurance Address: _____

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