School of Orthodontics
BROOKS REHABILITATION
COLLEGE OF HEALTHCARE SCIENCES

Insurance Information

Brooks Rehabilitation College of Healthcare Sciences, School of Orthodontics will file insurance claims as a courtesy to our patients when hardware is placed in the patient's mouth. Pre-authorization is the responsibility of the Subscriber (Policyholder). Insurance coverage is not a guarantee; therefore treatment cost is the sole responsibility of the Financially Responsible Party. Any discrepancy with insurance is the Subscriber's responsibility to resolve. **Note:** Where signatures of the Subscriber are called for, they must be those of either the Insurance Subscriber (Policy Holder) or his or her legal spouse.

In order for insurance benefits to be filed, it is essential that *all* of the information requested below is provided.
If you know that your dental insurance does not include orthodontic coverage, you do not need to fill out this form. If you are not certain, please complete the form.

Dental Insurance

Insurance Company: _____
Ins. Co. Address: _____
_____
_____
City State Zip
Ins. Co. Phone: _____
Group/Policy # _____
Subscriber's Name _____
(Policy Holder)
Relationship to Patient: _____
Subscriber's DOB: _____
Subscriber's SS# _____
Subscriber's Employer:_____

Authorizations:

1. Patient'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/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 Subscriber (Policyholder) Date

Dental Insurance

Insurance Company: _____
Ins. Co. Address: _____
_____
_____
City State Zip
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Group/Policy # _____
Subscriber's Name _____
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