CONFIRMATION OF INSURANCE BENEFITS

As a courtesy to you, our office will gladly file your insurance claims for orthodontic benefits as required by your carrier.

Please complete the two sections below. If incomplete, we will be unable to file your insurance claims.

Section 1: This information can be found on your insurance card

Patient Name _____
Relationship to Insured (self, child or spouse) _____
Name of Insured (parent or guardian, if patient is a minor) _____
Date of Birth of Insured _____
SS # of Insured _____
Insurance ID # on front of card _____
Employer: Name _____
Address _____
Insurance Company: Name _____
Mailing Address _____
City _____ State _____ Zip _____
Telephone # _____
Web Address: www._____

Section 2: Please contact your insurance company or employer's insurance representative to complete the following.

Date insurance company called: _____ Spoke with:_____

Please ask the following questions:

- Effective date: _____
- Is there coverage for orthodontic treatment? _____Yes _____No
- Is there an age limit? _____Yes _____No If so, what is the age limit? _____
- What is the reimbursement percentage? _____ (usually 50% or 70%)
- What is the lifetime maximum benefit? _____ or yearly maximum? _____
- How are benefits paid? Monthly _____ Quarterly _____ Other _____
- Are continuation of treatment claims required during treatment? _____Yes _____No
- Will you reimburse the insured in a lump sum if account is paid in full when braces are placed? ____Yes ____No
- Is there a yearly deductible? _____

Comments: _____

Please return completed form at your initial appointment.