North Seattle Orthodontics

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ORTHODONTIC INSURANCE INFORMATION

In order to assist you in determining your orthodontic benefits, the following information is necessary:

Name of Patient: _____ **Date of Birth:** _____

Name of Insured: _____ **Date of Birth:** _____

Address of Insured: _____

Soc Security # or ID #: _____ **Telephone #:** _____

Employer Name: _____ **Telephone #:** _____

Insurance Company: _____ **Group #:** _____

Insurance Company Address: _____

Insurance Company Telephone #: _____ **Primary or Secondary?** _____

Effective Date: **~FOR OFFICE USE ONLY~**

Date chkd: _____ **Chkd by:** _____ **Contact person:** _____

LTM: $ _____ **year / lifetime** **Paid at:** _____ **%** **Deductible: $** _____

age limit: _____ **need to pre-authorize?** _____

Amount used to date? $ _____ **Does plan pay a banding fee?** _____

How is benefit paid? **monthly/quarterly/ 2 pay plan/annual/other** **we bill ~or~ auto**

if coverage is secondary, how is benefit paid? _____

comments: _____

_____

Waiting Period: If yes, how long? **Electronic Payer ID #:**

Is patient covered under another dental plan? If so, please complete another insurance form:

I hereby authorize release of any information relating to this claim.

_____ **Date:** _____

Signature

I hereby authorize payment of insurance benefits directly to the above named orthodontists.

_____ **Date:** _____

Signature

Please notify our office of any changes in your insurance policy as soon as possible, thank you.