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Do you have orthodontic insurance benefits? Y N

If so, please read the following and provide the requested information so we may file any applicable insurance claims on your behalf. Please also bring your insurance card(s) to your initial appointment.

A WORD ABOUT INSURANCE PAYMENTS

The majority of insurance policies pay only a percent of the orthodontic fee based on your employer's contract with them. Ultimately, what your insurance carrier pays is between you, the carrier and the contract between your employer and the insurance carrier.

Upon presentation of your insurance card, we attempt to obtain a verbal description of coverage prior to claim submission. Verbal confirmation, however, does not guarantee payment. Benefit determination can be made only when a claim is submitted, payable subject to your plan provisions and the coordination of benefits with other group plans when applicable.

AUTHORIZATION STATEMENT

I authorize the release of information necessary to process any claim for services provided by Nash Orthodontics, and payment of benefits directly to Nash Orthodontics. A copy of this authorization may be used in place of the original. I understand that I am responsible for any balances not covered by insurance.

Patients/Parents or members are responsible for notifying Nash Orthodontics of any changes in orthodontic coverage, policy status, or change of carrier/administrator.

PATIENT'S NAME _____ DOB _____

INSURED (employee with Insurance) _____ DOB _____

INSURED'S SS# _____ EMPLOYER _____

INSURANCE CO: _____ PHONE _____

POLICY # _____ (is sometimes SS#) GROUP# _____

INSURED'S SIGNATURE _____ **DATE** _____

FOR OFFICE USE:

PT NAME _____ **DOB** _____

INSURANCE CO _____ PHONE _____

CLAIM ADDRESS _____

FAX CLAIMS? Y N Fax _____

INSURED _____ **DOB** _____ *P S*

ID _____ **GROUP** _____ **EMPLOYER** _____

Spoke with _____

LTM _____ USED? _____ **REMAINING** _____

% _____ Deductible? Y N \$ _____ ANN ONCE Age Limit? _____

WAIT PD? Y N _____ PRE-EXIST? _____

Payable to Ofc? Y N AUTO? Y N MTHLY QTRLY OTHER: _____

COB? _____

INSURANCE CO _____ PHONE _____

CLAIM ADDRESS _____

FAX FORMS? Y N Fax _____

INSURED _____ **DOB** _____ *P S*

ID _____ **GROUP** _____ **EMPLOYER** _____

Spoke with _____

LTM _____ USED? _____ **REMAINING** _____

% _____ Deductible? Y N \$ _____ ANN ONCE Age Limit? _____

WAIT PD? Y N _____ PRE-EXIST? _____

Payable to Ofc? Y N AUTO? Y N MTHLY QTRLY OTHER: _____