PHELPS & COHEN ORTHODONTICS

INSURANCE VERIFICATION & AUTHORIZATION FORM

We will be happy to verify and file your insurance for your orthodontic treatment. Please complete the following information and provide us with a copy of an insurance card. Also, signing the automation below gives us permission to obtain insurance information and file your claim.

DENTAL INSURANCE INFORMATION **Date** _____

Patient's Name _____ **Birthdate** _____

Subscriber's Name _____ **Birthdate** _____

Relationship to Patient: ☐SELF ☐SPOUSE ☐MOTHER ☐FATHER ☐STEPPARENT

Subscriber's Employer _____

Insurance Company _____

Insurance Co. Address _____

Group # _____ **or Union Local #** _____

***ID #** _____ **Effective Date** _____

*This is usually the insured's Social Security # or they may have assigned you a "unique" identifier. If it is your Social Security # and it is "truncated" on your card, we still need the full number to file. Thank you.

If you are filling out this form because you have new insurance from what we have on file for you, is this because of a job change or did your employer just change insurance carriers? ☐NEW JOB ☐SAME EMPLOYER/New Carrier Information

If you have a second insurance company, please complete a separate form for that company.

AUTHORIZATIONS

I have been informed of the treatment and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit 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 information to carry out payment activities in connection with this claim.

Parent/Guardian Signature _____ **Date** _____

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

Subscriber Signature _____ **Date** _____

OFFICE USE ONLY

Benefit information

LTM: $_____ **Payable at: %**_____ **Benefit remaining:** $_____ **Waiting period:** ☐No ☐Yes (____month)

Payment schedule: ☐Bill ☐Auto – ☐Monthly ☐Quarterly ☐Semi-Annually ☐Annual **Deductible: $**_____☐Annual ☐Lifetime

Age limits: Child_____ Stdnt_____ ☐Adult **COB Rule:** ☐Standard ☐Non-Dup **Cover Tx in progress**: ☐Yes ☐No