DISCLOSURE OF INSURANCE INFORMATION

PLEASE HAND YOUR MEDICAL AND DENTAL INSURANCE CARDS IN WITH THIS FORM SO WE CAN COPY THEM

1. We must have full disclosure of all medical and dental insurance policies in order to determine benefits for surgery.
2. We file our claims electronically so it is important that all fields are completed.
3. The biggest reasons our claims are denied are:
    a) Incorrect policy holder's name, birthdate & address was listed.
    b) Proof of the patient's student status has not been sent to the insurance carriers.
    c) Secondary insurance coverage information has not been updated with the primary insurance carrier.
    d) Patient has not confirmed that their new policy has been set up and is ready to receive claims.
    e) Failure to disclose correct Medicare number & any supplemental policies.

MEDICAL: **"PRIMARY" Insurance Company**

Employer _____ ___ Retired
Employer / Business Phone # _____
Insurance Company _____
and Address _____

_____
Customer Service Phone # _____
Group # _____
Policy Holder's I.D.# (if no I.D.# enter Policy Holder's S.S #)

_____
Name of Policy Holder _____
Policy Holder's "BIRTHDATE" _____
Is Policy Holder ☐ Male ☐ Female
Relation to Patient _____
Policy Holder's Hm Phone + Address (if different from patient)

_____
_____

DENTAL: **"PRIMARY" Insurance Company**

Employer _____ ___ Retired
Employer / Business Phone # _____
Insurance Company _____
and Address _____

_____
Customer Service Phone # _____
Group # _____
Policy Holder's I.D.# (if no I.D.# enter Policy Holder's S.S #)

_____
Name of Policy Holder _____
Policy Holder's "BIRTHDATE" _____
Is Policy Holder ☐ Male ☐ Female
Relation to Patient _____
Policy Holder's Hm Phone + Address (if different from patient)

_____
_____

MEDICAL: **"SECONDARY" Insurance Company**

Employer _____ ___ Retired
Employer / Business Phone # _____
Insurance Company _____
and Address _____

_____
Customer Service Phone # _____
Group # _____
Policy Holder's I.D.# (if no I.D.# enter Policy Holder's S.S #)

_____
Name of Policy Holder _____
Policy Holder's "BIRTHDATE" _____
Is Policy Holder ☐ Male ☐ Female
Relation to Patient _____
Policy Holder's Hm Phone + Address (if different from patient)

_____
_____

DENTAL: **"SECONDARY" Insurance Company**

Employer _____ ___ Retired
Employer / Business Phone # _____
Insurance Company _____
and Address _____

_____
Customer Service Phone # _____
Group # _____
Policy Holder's I.D.# (if no I.D.# enter Policy Holder's S.S #)

_____
Name of Policy Holder _____
Policy Holder's "BIRTHDATE" _____
Is Policy Holder ☐ Male ☐ Female
Relation to Patient _____
Policy Holder's Hm Phone + Address (if different from patient)

_____
_____

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid to my physician and I understand that I am responsible for any deductibles, co-payments, non-covered services, amounts that a carrier determines is over and above "their" usual and customary allowance, etc.. I also authorize my physician to release any information required to process my insurance claim(s).

SIGNATURE _____ Date _____

PATIENT OR RESPONSIBLE PARTY