INSURANCE VERIFICATION FORM - SIREE ORTHODONTICS

In order to assist you in verifying your orthodontic insurance benefit, the following information

MUST BE FILLED OUT COMPLETELY:

Patient's Name_____ **Date of Birth**_____

Name of Person Who Carries the Insurance:_____**Date of birth**_____

Social Security #_____**ID#**_____**Ph #:**_____+____

Employed By:_____Business Phone #: _____

Address: _____

Insurance Company:_____ _**Policy/Group #:**_____

Address of Insurance Company:_____

City/ State_____**Zip**_____**Ins Company ph#**_____

If patient is covered under another Dental Plan, please complete another insurance form.

I hereby authorize release of any information relating to this claim and authorize payment directly to the named orthodontist of the insurance benefits.

Signature_____Date_____

FOR OFFICE USE ONLY

Date verified_____ **Verified by**_____

PRIMARY

Name of Insurance:

Spoke with_____coverage **Y/ N** Effective date_____

In network: LTM_____ pays at _____%
Deductible _____Wait_____

Out of network: LTM_____pay at_____%
Deductible _____Wait_____
Age Limit_____/_____
How are benefits paid out: **Auto or Bill**
Monthly Quarterly Semi-Annual Annual Other
Have any benefits been used **Y/ N** How much_____
Balance left _____
Coordination of Benefits:_____
Pre-Existing/Will treatment in progress be pro-rated **Y N**
Coverage for space maintainer?_____

Confirm Ins. address: PO.Box_____ **State**_____

Zip code:_____ **Phone#**_____

Grp#_____ **ID#**_____