Cosmetic, Implant & Restorative Dentistry

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Dear Patient,

We are happy to assist you in the filing of your dental claim forms. In order to do this, we are required to provide your insurance carrier with the following information.

We can process most dental claims electronically. Whether a claim can be processed electronically depends on the insurance carrier.

If you prefer not to provide this information or if you prefer to handle this yourself, we will provide you with a universal claim form. You may attach that form to your completed dental claim form for reimbursement.

If you are both the insured and the patient, we only need the information once. Please provide us with the patient information. If you are not the insured, we need both the patient and subscriber's information. Thank you.

Primary Insurance Plan Information:

Patient's Name: ____

Insured's/Subscriber's Name: ____

Relationship to the insured: Self / Spouse / Child / Other:_________________________

Subscriber ID # or Social Security #: ____________________________

Subscriber Date of Birth: ______________________

Patient's ID # or Social Security #: _____________________________

Patient's Date of Birth: _______________________

Employer/Company Name: ____

Employer Plan # / Policy # / Group #:____

Union Local: _________________________ **Union Name:**__________________________________

Insurance Co. Name: ____

Insurance Co. Payer ID #: ____________________________ *(Payer ID # is required so we may file electronic claims)*

Insurance Co. Mailing Address:____

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I authorize the release of any information relating to this claim:

Patient Signature: ___________________________________ Date: ___________

We do not accept assignment of dental benefits. Your insurance carrier will reimburse you directly based on the plan purchased by your employer.

If you have additional insurance coverage, we will need the same information for those plans. Kindly indicate which plan is primary and secondary. Thank you.