BURROW
ORTHODONTICS

ORTHODONTIC INSURANCE INFORMATION

In order to assist you in determining your orthodontic insurance benefit, the following information is necessary:

Name of Patient: _____ Date of Birth: _____

Name of Insured: _____ Date of Birth: _____

Address: _____

Social Security #: _____ Telephone: _____

Employed by: _____

Address:_____

Address of Insurance Company: _____

Insurance Company Telephone: _____ Is this policy a HCR Health Care Reform Policy? YES NO

Policy/Group/ID #:_____ Member ID#_____

I hereby authorize release of any information relating to this claim.

_____ ***Date:*** _____

Signature

I hereby authorize payment of insurance benefits directly to the above named orthodontist.

_____ ***Date:*** _____

Signature

Please notify our office of any changes in your insurance policy as soon as possible.

FOR OFFICE USE ONLY

Effective Date: _____

Benefit Amount: _____ Benefit Used: _____

Do you pay out of network benefits? Yes _____ No _____ Pays at _____%

Do you cover work in progress? Yes ____ No _____ Age Limit: Yes _____ (what age) No _____

Is pre-authorization required: Yes _____ No _____ Waiting Period: Yes_____ No ____

Deductible: Yes $_____ No_____ Payer ID: _____

Method of Payment: Monthly _____ Quarterly _____ Annual _____ Other _____

Date confirmed_____ Staff who confirmed_____ Spoke with whom_____