IN ORDER TO PROPERLY FILE FOR ORTHODONTIC BENEFITS, WE REQUIRE THE FOLLOWING INFORMATION:
(If any part of the insurance balance is not paid, it does remain the patient's responsibility)

NAME OF PATIENT: _____ **DATE OF BIRTH:** _____

PRIMARY DENTAL COVERAGE

PLACE OF EMPLOYMENT OF INSURED: _____

ADDRESS OF EMPLOYER: _____

EMPLOYERS TELEPHONE NUMBER: _____

PRIMARY INSURED'S NAME: _____

PRIMARY INSURED'S BIRTH DATE: _____ SOCIAL SECURITY#: _____

PATIENT'S RELATIONSHIP TO INSURED: _____

INSURANCE COMPANY NAME: _____

INSURANCE COMPANY ADDRESS: _____

TELEPHONE NUMBER: _____ ID#: _____

****ADDR/GRP# VERIFIED** _____

SECONDARY DENTAL COVERAGE

PLACE OF EMPLOYMENT OF INSURED: _____

ADDRESS OF EMPLOYER: _____

EMPLOYERS TELEPHONE NUMBER: _____

SECONDARY INSURED'S NAME: _____

SECONDARY INSURED'S BIRTH DATE: _____ SOCIAL SECURITY#: _____

PATIENT'S RELATIONSHIP TO INSURED: _____

INSURANCE COMPANY NAME: _____

INSURANCE COMPANY ADDRESS: _____

TELEPHONE NUMBER: _____ GROUP#: _____

****ADDR/GRP# VERIFIED** _____

I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

SIGNATURE: _____ DATE: _____

I HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS DIRECTLY TO SAKS ORTHODONTICS.

SIGNATURE: _____ DATE: _____

FOR OFFICE USE ONLY

Ortho Coverage? Yes ☐ No ☐ Lifetime Maximum _____ Payable @ _____ % Deductible _____

Eective Date _____ Lifetime Maximum Met _____ Age Limit _____ Deductible Met _____

Monthly _____ Quarterly _____ Aut _____ As Field _____ Payable on Fee Schedule _____ Initial _____ Balance _____

Pay Provider _____ VERIFIED BY _____ DATE _____ Spoke With _____