Instructions: Prior to your appointment, please call your insurance company, print and complete this form in its entirety and fax or e-mail back to us.

PATIENT INSURANCE VERIFICATION FORM

Patient Name: _____
Date of Birth: _____

Primary Insurance:

Insured: _____
Date of Birth: _____SS or ID#_____
Employer: _____Group# _____
Insurance Company: _____Phone# _____
Insurance Company Address: _____
City: _____State:_____ Zip: _____

PLEASE ASK YOUR INSURANCE COMPANY REPRESENTATIVE THE FOLLOWING QUESTIONS:

What is the effective date of my coverage? _____
What is the individual lifetime orthodontic maximum covered? _____
At what percentage is the benefit paid? _____ (Usually 50%)
Do we have a deductible? Yes_____ No_____
If yes, is it annual or lifetime? _____ Amount: _____
Is the benefit paid to my Orthodontist automatically? Please check below:
Monthly_____ Quarterly_____ Annually _____ Semi Annually _____
Do you pay out of network benefits? _____
Is there a waiting period? ___ Is there an age limit? ___ What is the age limit? __
Are spouse and employee covered Yes___ No ___
Have any benefits for Orthodontics been used:_____
Is there a time limit to file? _____
Verified by: (Name of person from insurance company you spoke with)
Name: _____ Date: _____
If this was an automated call, please initial: _____Date: _____

I understand that estimated benefits quoted to me and/or Dr. Gragg by my insurance company are not a guarantee of payment and that I am responsible for any and all fees not paid by my insurance company.

Signature of Insured: _____ Date: ____
Please Print Name: _____