Dear Parents – **PLEASE, PLEASE, WE NEED YOUR HELP**

If you have dental insurance coverage we will be happy to file your forms as a courtesy, but to do so we need all the correct insurance information. We do not know the specific benefits that your dental insurance provides. **We are not an HMO or PPO insurance contracted office, we are considered "out of network." Therefore, you are responsible for the balance after insurance pays. (_____)**

Initials

HELP US -- HELP YOU

We need the following documentation for each new series of Dental Treatment, otherwise we cannot file your claim forms correctly.

Name(s) of Child(ren) _____

Name of Insurance Co. _____
Address of Insurance Co. _____
Phone # of Insurance Co. _____
Group # _____
Subscriber's Name _____
Subscriber's Employer _____
Subscriber's Social Security # _____
Subscriber's Date of Birth _____
Subscriber I.D. # _____
Plan Effective Date _____

If you have Dual Insurance:

Name of 2nd Insurance Co. _____
Address of 2nd Insurance Co. _____
Phone # of 2nd Insurance Co. _____
Group # of 2nd Insurance Co. _____
Subscriber's Name _____
Subscriber's Employer _____
Subscriber's Social Security # _____
Subscriber's Date of Birth _____
Subscriber I.D. # _____
Plan Effective Date _____

Which Insurance Company is the Primary Coverage? _____

There will be a **$20.00** (twenty dollar) charge for each claim form that has to be **RESUBMITTED** because of incorrect information that you have provided to us.

Thank you for your help. This ensures that we can file your insurance correctly the first time.

Signature _____ Date _____