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 Primary 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 _____

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 _____**

By law your insurance company is required to pay each claim within 30 days of receipt. We file all insurance electronically so your insurance company will receive each claim within days of the treatment. You are responsible for any balance on your account after 60 days, whether insurance has paid or not.