CHANGE OF INSURANCE FORM

Date _____

This is NOT a guarantee of benefits or payment. Actual benefits can not be determined until actual claim is received by carrier. As per contract patient is responsible for any balance denied or rejected by insurance carrier

Patient Name _____ Account Number _____

Date of Birth _____ Location _____ Initial Start Date _____

Policy Holder's Name _____ Policy Holder DOB_____

Policy Holder's Address _____Zip Code_____

Employer _____ Insurance Company _____

Insurance Co. Phone Number _____ Group Number _____

Policy Holder Social Security Number _____

****Copy of Insurance card attached****

INFORMATION AND PAYMENT AUTHORIZATION RELEASE

I authorize the release of any information relating to this claim and understand that I am responsible for all costs of dental treatment.

_____/_____
Signature (responsible party) Date

I hereby authorize payment directly to **Family Orthodontics** of the group insurance benefits otherwise payable to me.

_____/_____
Signature (responsible party) Date