Laura Glicksman, DMD, PC 119 Chestnut St. Needham MA 02492 781-449-3560

READ BOTH SIDES
SIGN BELOW

DENTAL INSURANCE INFORMATION

Our office is happy to file your insurance to help you receive the dental benefits that you are entitled to. Please be aware, however, that orthodontic benefit plans vary amongst companies, as do the ways these plans address orthodontic fees. Most dental insurance companies base the amounts that they will pay towards your orthodontic treatment on a lifetime maximum payable at a certain percentage of the treatment fee. Some insurance plans will only consider what it allows for orthodontic treatment, regardless of what our actual fee might be, and then apply the percentage to their allowable charge.

In addition to providing our treatment fee and the breakdown of this fee, insurance companies ask us to supply the starting date of treatment, and the dates that initial and monthly fees are due. Both our office, and you as the policy beneficiaries, can be prosecuted if we do not provide accurate dates and fees. We **will not**, under any circumstances, modify this information to maximize your benefits. However, we will do everything within our power to assist you in getting what you deserve.

1. All fees for treatment are the responsibility of the individual patient or his family, and are not the responsibility of the insurance company. We ask that you collect your benefits directly from the insurance company**. Please do not assign benefits to our office.** The insurance company should make checks payable to you. Please feel free to ask why we do not accept the assignment of orthodontic benefits. One of the primary reasons is that financial supplement from your insurance plan may terminate at any time for a number of reasons, including a change of employment.

2. If your insurance company requires a special form be used, please bring your **filled out** and **signed** insurance form to our office, **along with your payment**. If your plan does not require its own form, please fill out the insurance information on the other side, and we will use our generic forms.

3. Please note that we will send your **initial form** to your insurance carrier once you have provided it to us, however, it is your responsibility to keep us informed of any further submissions required. This includes charges for all pretreatment visits after the initial exam, as well as the actual treatment fee, once treatment has started. Even during treatment, some insurance companies require annual, quarterly, or even monthly submissions to continue the schedule of reimbursement payments. It is your responsibility to inform us of these requirements.

4. **Please keep track of your insurance payments, and check directly with your insurance carrier if you do not receive reimbursement.** Remember, we **will not** be held responsible for lost benefits if submission deadlines are not met.

Again, we will be happy to assist you in submitting your claims. If you should have any questions, please feel free to ask or call me at 781-449-3560.

Thank you,

Millie
Insurance Coordinator

Signature _____ Date _____

PLEASE TURN OVER TO COMPLETE FORM

DENTAL INSURANCE INQUIRY FORM

Date _____

Patient's Name _____ DOB _____
Mm/dd/yy

Subscriber's Name _____ DOB _____
Mm/dd/yy

Subscriber's Insurance ID #_____

Insurance Company _____

Address _____

Toll Free Number _____

Employer _____

Group Number _____

Please note: If you have another insurance please fill out another form

FOR OFFICE USE ONLY

Subscriber # is (above). Give patient's name.

Is there orthodontic coverage? Yes _____ No _____

If yes – Is there and age limit? Yes _____ No _____

Effective date of coverage _____
Waiting period Yes _____ No _____
If yes how long _____

Current eligibility

Coverage _____% usual and customary
OR
_____ Table of allowance Initial _____ Monthly_____

Deductible (IF any) $ _____ Lifetime_____ Yearly _____

Maximum _____ Lifetime _____ Yearly _____

Submit Insurance Form: Monthly _____ Quarterly _____ Yearly _____

Has any ortho benefit previously been uses? Yes _____ No _____
If yes $_____ Paid to whom? Dr. _____

Name of person spoken to _____
Date of call _____

PLEASE TURN OVER TO COMPLETE FORM