Martin
ORTHODONTICS

Insurance Information

The following information regarding your orthodontic insurance coverage is necessary to process your insurance claim. Please complete the following as completely as possible to expedite your claim and to insure that you receive the maximum benefit availble.

Please remember your insurance is a contract between you and your insurance provider. You are responsible for understanding your benefits and limitations.

Employee Name: _____

Employee Address: _____

City/State/Zip: _____

Date of Birth _____ Social Security Number: _____

Insurance Company: _____

Insurance Company Address: _____

City/State/Zip: _____

Insurance Telephone Number: _____

ID #: _____

Plan or Group Number: _____

Employer Name: _____

Employer Address: _____

_____

Employer Telephone Number: _____

Secondary Insurance Company: _____

Employee Name: _____

Date of Birth _____ Social Security Number: _____

Insurance Company Address: _____

City/State/Zip: _____

Insurance Telephone Number: _____

ID #: _____

Plan or Group Number: _____

I authorize release of any information pertaining to this claim.

Signature: _____ Date: _____

I authorize payment of my insurance benefits directly to Martin Orthodontics.

Signature: _____ Date: _____