AUTHORIZATION TO FILE CLAIMS/SIGNATURE ON FILE

Employee/Subscriber's Name as shown on dental card or with Insurance Company:

First: _____ Middle Initial: _____ Last: _____

Employee/Subscriber's ID # or SS #: _____ Date of Birth: _____

Employee/Subscriber's Address: _____

_____

Group/Employer Name: _____ Group#: _____

Insurance Co: _____ Insurance Company Phone #: _____

*Please list patient's Dickey Dental is authorized to file Employee/Subscriber's Insurance on: **(please include self)***

1. _____ Date of Birth: _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

- ◯ I authorize release of any information concerning my or my child's healthcare recommendations and treatment for the purpose of evaluation and administering claims for insurance benefits.
- ◯ I authorize all insurance benefits payable by my plan to be paid directly to Dickey Dental.
- ◯ I understand that if the insurance company pays the subscriber/policyholder directly, all balances are due immediately.
- ◯ I understand that Dickey Dental does not guarantee payment from your insurance company and any estimates given are based on coverage provided from you insurance provider.
- ◯ I understand that any portion of my treatment not covered by insurance is my responsibility.

Patient/Responsible Party's Signature: _____ Date: _____

Yearly, this form must be signed and a copy of your **dental (not medical) insurance card** and/or a claim form from your insurance company with the address, phone#, group# and Employee ID# on it must be obtained to file your insurance benefits. Thank you