Michigan Orthodontic Specialists

Please bring your insurance card and know your orthodontic coverage prior to your appointment or it may delay the filing of your insurance benefit. Call your Insurance Carrier or Human Resources representative with any questions.

PRIMARY INSURANCE SUBSCRIBER INFORMATION:

First / Last Name:_____Middle Initial:_____

Relationship to Patient: _____

Subscriber Identifier (SSN or ID #):_____ Date of Birth:_____

Address/City/State/Zip:_____

Employer Name:_____

Insurance Carrier:_____

Address/City/State/Zip:_____

Member ID #:_____ Group #: _____

Lifetime Maximum:_____ Payable at:_____% Effective Date:_____

SECONDARY INSURANCE SUBSCRIBER INFORMATION:

First / Last Name:_____Middle Initial:_____

Relationship to Patient: _____

Subscriber Identifier (SSN or ID #):_____ Date of Birth:_____

Address/City/State/Zip:_____

Employer Name:_____

Insurance Carrier:_____

Address/City/State/Zip:_____

Member ID #:_____ Group #: _____

Lifetime Maximum:_____ Payable at:_____% Effective Date:_____

AUTHORIZATIONS:

I agree to be responsible for all charges for orthodontic services and material not paid by my dental benefit plan. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X_____
Patient/Guardian Signature Date

I hereby authorize and direct payment of orthodontic benefits payable to Michigan Orthodontic Specialists/
Dr. James L. Souers-Orthodontist.

X_____
Signature of Primary Subscriber Date Signature of Secondary Subscriber Date