Insurance Claim Form

Insurance Company ____

Insurance Comp. Phone # ____

Member ID# ________________________Group#____________________________

Patient's Full Name ____
First MI Last

Patient's Birthdate: _________________________
MM DD YY

Patient's SS#_______________________________

Employee/Subscriber Name____

Employee/Subscriber SS#____

Employee/Subscriber Birthdate_________________________________
MM DD YY

Employer/Company Name____

Is patient covered by Medicaid? Yes No

Payment is required at the time of service unless prior arrangements have been agreed upon. As a reminder, we file your insurance as a courtesy. Any claims unpaid by your insurance company after 40 days are your responsibility. Any balance carried over 90 days from the date of service will be forwarded to our collection agency. Your signature authorizes **Alexandria Pediatric Dentistry** to file your insurance and to instruct the insurance company to send payment directly to our office.

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Signature Relationship Date