INSURANCE INFORMATION

*ALL INSURANCE INFORMATION MUST BE COMPLETELY FILLED OUT IF YOU WISH US TO SUBMIT A CLAIM ON YOUR BEHALF. WHILE WE WILL MAKE EVERY ATTEMPT TO OBTAIN REIMBURSEMENT FOR YOU WE CANNOT GUARANTEE WHAT, IF ANYTHING YOUR CARRIER(S) WILL PAY, NOR THE AMOUNT OF TIME IT WILL TAKE FOR THEM TO PROCESS CLAIMS.

PRIMARY Policy Holders Information

Last: _____ First: _____ MI _____
Birth Date: _____/_____/_____ SS# _____-_____-_____ Sex: _____ Age: _____
Street Address:_____ City: _____ State: _____ Zip: _____
Home phone: ( ) _____-_____ Work phone: ( ) _____-_____
Employer name:_____Employer address:
Street_____
City_____State:_____Zip: _____

#1 Primary Dental Insurance info:
Insurance Company Name:_____
Address to Submit Claims:_____ City: _____ State: _____ Zip: _____
Ins. Co. Phone #: ( ) _____-_____ Member ID #: _____ and/or Group#_____

#1 Primary Medical Insurance info:
Insurance Company Name: _____
Address to Submit Claims:_____ City: _____ State: _____ Zip: _____
Ins. Co. Phone #: ( ) ____-_____Member ID #: _____ and/or Group#_____

SECONDARY Policy Holders Information

Last_____ First_____ MI_____
Birth Date_____/_____/_____ SS#_____-_____-_____ Sex:_____ Age:_____
Street Address:_____ City:_____ State:_____ Zip:_____
Home Phone: ( ) _____-_____ Work phone: ( ) _____-_____
Employer name:_____Employer address:
Street_____
City_____State:_____Zip: _____

#2 Secondary Dental Insurance info:
Insurance Company Name:_____
Address to Submit Claims:_____ City: _____ State: _____ Zip: _____
Ins. Co. Phone #: ( ) ____-_____ Member ID #: _____ and/or Group#_____

#2 Secondary Medical Insurance info:
Insurance Company Name: _____
Address to Submit Claims:_____ City:_____ State: _____ Zip: _____
Ins. Co. Phone#: ( ) ____-_____Member ID #: _____ and/or Group#_____