Dental Insurance Data Update

To assist you with efficient filing of your dental insurance, we will be happy to file your claims electronically. Electronic filing requires accurate and complete information. Please complete the information below so that we can audit your data in our computer. **Please complete ALL of the information below so that we can verify the information in our computer.**

DENTAL INSURANCE POLICY HOLDER:

_____

Policy holder's SSN: _____ Date of Birth: _____

Policy holder's **Employer:** _____

Employer Address: _____

(Corporate or Home Office preferred)

City: _____ State: _____ Zip: _____

Employer Telephone: _____

(Corporate or Home Office preferred)

Insurance Company: _____ Effective Date: _____

Group Number: _____ Payer ID#: _____

Claims Processing Address of Insurance Company:

_____

City: _____ State: _____ Zip: _____

Insurance Company's 800 Number: _____

Dependent(s) covered on this policy:

_____

SIGNATURE ON FILE

I authorize release of information to all insurance companies and permit this copy of my signature to be kept on file for processing dental insurance claims for me and my dependents. I authorize payment to go directly to my dentist. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents, is mine. I also understand this dental office only has a contract with Met Life Insurance. I agree to pay my deductible and any portion of the dental fee not covered by my dental insurance plan at the time of service. I will notify this office if I have a change in my dental coverage.

Subscriber/Guarantor Signature: _____

Date: _____