

## CONFIRMATION OF ELIGIBILITY FOR ORTHODONTIC SERVICES

In order for the insured to know and better understand his or her insurance coverage, the following form is being provided. Your cooperation in its completion will be appreciated by the insured and the orthodontist.

### TO BE FILLED OUT BY PATIENT

Date \_\_\_\_\_

Name of Patient \_\_\_\_\_ Age \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship \_\_\_\_\_

Employer and/or Union \_\_\_\_\_

S.S.N./S.I.N. of Insured \_\_\_\_\_

### TO BE FILLED BY THE INSURED'S EMPLOYEE BENEFITS DEPARTMENT

Eligibility  Yes

No If not eligible, are X-rays or Diagnostic Procedures Covered?  Yes  No

Contract Identification \_\_\_\_\_

Contract Number \_\_\_\_\_

Benefits under this program are subject to the following:

Deductible Amount \_\_\_\_\_

Coinsurance Factor \_\_\_\_\_

Maximum Orthodontic Benefits \_\_\_\_\_

Have orthodontic benefits been reduced by previous treatment?  Yes  No

Total fees for previous treatment \_\_\_\_\_

Total remaining benefits \_\_\_\_\_

Is payment guaranteed throughout treatment, once initiated, irrespective of changes in status of insured?

Yes  No

Other exclusions which may affect coverage \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_

**PLEASE RETURN COMPLETED FORM TO INSURED**