Dr. Richard D. Hulme, DDS, MS **HULME ORTHODONTICS, P.A.**

Orthodontic Insurance Information

Today's Date:_____/____/_____

Patient's Name: _____ DOB:____/____/_____ Age: _____

Subscriber's Name: _____ DOB:____/____/_____

Subscriber's **Social Security #**: _____/_____/_____

Subscriber's **Member ID**: _____

Subscriber's Employer: _____ GRP #: _____

Name of Insurance(s): _____

Insurance Phone #: 1 - _____-_____-_____

Insurance Address: _____
_____
_____

I hereby authorize release of any information relating to the insurance benefits of this claim and payment directly to the above named orthodontist.

SIGNATURE_____

For Office Use Only

Date Insurance was Verified: _____
Name of Person Spoken with: _____

Ortho Coverage: Yes / No Effective date: _____
Waiting period: Yes / No If yes, how long? _____
Deductible: $_____ Met? Yes / No One-time / yearly
Coordination of Benefits: Standard / Non-Duplicating
Accept treatment in progress? Yes / No
Paid to: Subscriber / Provider (assignment of benefits)
Age Limit: _____
In Network Coverage: $_____ Pays at _____%

Maximum will pay out per calendar year: _____
Maximum will pay out per month: _____
Ins. Pays: monthly / quarterly / one-time Auto: Yes / No
Initial Down Payment: _____%
Dual Coverage: Primary / Secondary

Lifetime Maximum:
$_____

Pays at:
_____%

Remaining Benefits:
$_____