PLEASE HELP US WITH YOUR INSURANCE INFORMATION

KINDLY PROVIDE **ALL** OF THE FOLLOWING INFORMATION OR PAYMENT WILL BE EXPECTED AT THE TIME OF SERVICE. THANK YOU.

PATIENT NAME____

EMPLOYEE NAME____

NAME OF INSURANCE COMPANY____

ID #____**GROUP #**_______________________________

SS # OF EMPLOYEE___________________________**EMPLOYEE BIRTHDATE**_____________

BILLING ADDRESS OF INSURANCE COMPANY______________________________________

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PHONE NUMBER OF INSURANCE COMPANY_______________________________________

IF YOU HAVE DUAL INSURANCE PLEASE COMPLETE THE FOLLOWING:

EMPLOYEE NAME____

NAME OF INSURANCE COMPANY____

ID #____**GROUP #**_______________________________

SS # OF EMPLOYEE___________________________**EMPLOYEE BIRTHDATE**_____________

BILLING ADDRESS OF INSURANCE COMPANY______________________________________

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PHONE NUMBER OF INSURANCE COMPANY_______________________________________

WHICH OF THESE COMPANIES IS PRIMARY________________SECONDARY_______________

Assignment of benefits:
I authorize payment of group insurance benefits directly to Richard L. Daffurn, D.D.S.
Signature____Date_______________________

Release of information:
I authorize release of any information relating to this claim.
Signature____Date________________________

July, 2009