DIRECT BILLING DENTAL INSURANCE

If you request we bill your insurance for your visits we require the following information. Please realize we do not charge for this service and it is your responsibility to know the details of your dental insurance coverage and any limitations your plan may have. We do NOT have computer or telephone access to your information. The electronic insurance responses do not always give us the % covered on the services provided

We require the following information to secure your account:

1. Circle: Visa/MC Credit Card #:_____ Expiry Date: _____
*If unable to provide us with a valid credit card you are responsible for full payment of your dental treatment today. We will submit claims to insurance so you can be reimbursed.

2. Basic insurance information as per your patient chart you completed. Eg. Annual maximum, month plan year starts, % Basic, % Major

3. If you have an insurance booklet please bring to your next appointment. Knowing some basic information will help us to help you better understand your insurance.

You are required:

-To pay portion not covered by insurance on day of appointment.
-To know the terms and limitations of your insurance coverage.
-To let us know if you have to stay within a certain limit.

*Please note insurance companies can change your coverage at any time. Therefore, you should be reviewing you policy and keeping track of any notification from your employer regarding any changes to your insurance coverage.
*We follow the current Sask. Dental Fee Guide
*Remember, just because your insurance may cover 80% or 100%, it does NOT necessarily mean it covers all services. There are hundreds of dental services & some insurance companies have limitations. Your dental health is our concern, we do not let insurance companies dictate the treatment you require.

I request my insurance company be billed for treatment directly. I understand that insurance is my responsibility and in any event, I am responsible for paying my account. _____
INITIAL

If my insurance is late in paying my account, I will pay the outstanding balance and be responsible for collecting my insurance portion myself. _____
INITIAL

I agree to notify the dental office of any changes in my insurance coverage._____
INITIAL

I agree that my credit card number on file can be used to cover any of my outstanding balances. _____
INITIAL

SIGNATURE: _____DATE:_____