Fort Worth Office
4200 Bryant-Irvin Road, Suite 117
Fort Worth, Texas 76109
PHONE: (817) 731-8401
FAX: (817) 377-4317
EMAIL: info@kupermanortho.com

Burleson Office
240 SW Wilshire Boulevard
Burleson, Texas 76028
PHONE: (817) 295-7124
FAX: (817) 295-1429
EMAIL: info@kupermanortho.com

Date: ____________________

Insurance Eligibility and Benefit Determination

Patient

Name ______________________________ Patient No. __________

Primary Coverage

(this portion must be filled out completely)

Insured's Name ______________________________ Insured's SS No. __________

Employer Name ______________________________ Insured's Birthdate __________

Employer Address ______________________________ Employer Phone __________

Employer City/State ______________________________ Zip __________

Patient's relationship to insured ____Self ____Child ____Spouse

Insurance Company Name ______________________________ Group No. __________

Address ______________________________ Phone __________

City/State ______________________________ Zip __________

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I hereby authorize payment directly to the above named dentist of the group insurance benefits otherwise payable to me.

Signature ______________________________ Date __________

Secondary Coverage

Insured's Name ______________________________ Insured's SS No. __________

Employer Name ______________________________ Insured's Birthdate __________

Employer Address ______________________________ Employer Phone __________

Employer City/State ______________________________ Zip __________

Patient's relationship to insured ____Self ____Child ____Spouse

Insurance Company Name ______________________________ Group No. __________

Address ______________________________ Phone __________

City/State ______________________________ Zip __________

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I hereby authorize payment directly to the above named dentist of the group insurance benefits otherwise payable to me.

Signature ______________________________ Date __________

- **Please present your insurance card so that copies can be made.**
- **The benefits obtained from your carrier may be subject to change.**

For Office Use Only

☐ Self ☐ Spouse ☐ Family

Ortho Maximum________ ☐ Lifetime ☐ Annual Deductible________ ☐ Lifetime ☐ Annual Payment________

Effective Date________ Waiting Period________ Age Limit________

Prior benefits used________ Remaining benefit amount________

How is claim paid ☐ Monthly ☐ Quarterly ☐ Other________

Continuation treatment forms ☐ Not Required ☐ Required

Mail To________ Verified by________

________ Contact Person________

________ Date________

Group No.________ Payor ID No.________

Dup. Benefit? ☐ Yes ☐ No

For Office Use Only

☐ Self ☐ Spouse ☐ Family

Ortho Maximum________ ☐ Lifetime ☐ Annual Deductible________ ☐ Lifetime ☐ Annual Payment________

Effective Date________ Waiting Period________ Age Limit________

Prior benefits used________ Remaining benefit amount________

How is claim paid ☐ Monthly ☐ Quarterly ☐ Other________

Continuation treatment forms ☐ Not Required ☐ Required

Mail To________ Verified by________

________ Contact Person________

________ Date________

Group No.________ Payor ID No.________

Dup. Benefit? ☐ Yes ☐ No