Date: ____________________

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) 377-4317
EMAIL: info@kupermanortho.com

Insurance Eligibility and Benefit Determination

Patient

Name ______________________________ Patient No. ______________

Patient Birthdate ______________________________

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 ___ Step Child ___ Spouse Member ID ______________

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 ___ Step Child ___ Spouse Member ID ______________

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.**