Smith & Rockefeller FAMILY AND COSMETIC DENTISTRY

Christopher H. Smith, DMD
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ELECTRONIC CLAIMS

Subscriber of Policy (Insured Employee) _____

Dependent(s) covered on this policy _____

Out of courtesy to our patients we offer the convenience of filing insurance claims electronically. Our administrative staff will be happy to assist by filing your claims electronically, provided the information below is completed. Payment of your estimated patient portion is due on each date service is rendered. This portion of your bill will not be covered under your policy based on the information you provide to us. You are responsible for any portion of your charges in which payment has been denied or unpaid by your insurance company.
Please verify the information you have listed below is your Dental Benefits and not Medical by calling the 800 number on the back of your insurance card.

To send your claims electronically, we need you to pay:

1.) Your deductible if you have not met your deductible for the current plan year.
2.) Your co-payment (20% or 50%, whichever is applicable).

Plus please provide the following information regarding the insured/subscriber:

Social Security Number _____ Date of Birth _____

Subscriber ID Number _____ Work Telephone _____
(Number on your insurance card) (Corporate or Home Office preferred)

Employer _____ Union ☐ Yes ☐ No

Division # _____ Branch # _____ Sub # _____ Option _____

Address of Employer _____
(Corporate or Home Office preferred)

City _____ State _____ Zip _____

Insurance Company _____ Effective Date _____

Address of Insurance Co. _____

City _____ State _____ Zip _____

Ins. Co.'s 800 Number _____ Group Number _____ Payer ID# _____

SIGNATURE ON FILE

I authorize the release of information to my primary and secondary insurance companies (past and present) and permit this copy of my signature to be used in place of the original. My signature also applies to the dependents on my policy listed at the top of this form. I authorize payment to go directly to my dentist. I understand that all responsibility for payment for dental services provided in this office for myself and my dependents is mine. I also understand this dental office has no contract or connection with any dental insurance company. I take full responsibility to know and understand the terms, limitations and stipulations, deductibles, waiting periods and maximums as stated in my policy so I can inform this office of my policy benefits. I understand this office is not responsible for knowing the terms of my policy. I also realize most insurance companies no longer require pre-treatment estimates and only at my request will this request be forwarded to my carrier. I agree to pay any co-pay (patient portion) and the deductible at the time of service, unless prior arrangements have been made. I am aware of my responsibility in making sure my insurance carrier pays all claims in a timely fashion and that I will be expected to pay for any claim unpaid after 45 days. I am also aware that any unpaid portion for services denied by my insurance carrier is my responsibility and is due upon notification from my carrier or this office for any claim submitted by this office. I realize it is my responsibility to provide the information needed to process dental claims for myself and my dependents and is not the responsibility of this office. I will notify this office if I have a change in my dental coverage.

Subscriber/Guarantor Signature _____ **Date** _____

Patient's Signature _____ **Date** _____