

**HULME ORTHODONTICS, P.A.**

Dr. Richard D. Hulme, DDS, MS

**Orthodontic Insurance Information**

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Subscriber's Social Security #: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_

GRP/Policy #: \_\_\_\_\_

PRIMARY / SECONDARY (Please circle)

Name of Insurance (s): \_\_\_\_\_

Address:

\_\_\_\_\_

\_\_\_\_\_

Phone #: \_\_\_\_\_

I hereby authorize release of any information relating to the insurance benefits of this claim and payment directly to the above named orthodontist.

SIGNATURE \_\_\_\_\_

**For Office Use Only**

Name of Person Spoken with \_\_\_\_\_

Ortho Coverage: yes / no      Effective date: \_\_\_\_\_

Waiting period: yes / no      If yes, how long? \_\_\_\_\_

Deductible: \_\_\_\_\_ 1 x Ded /or yearly

Lifetime Maximum: \_\_\_\_\_ Pays at: \_\_\_\_\_ %

Age Limit: \_\_\_\_\_

Maximum will pay out per calendar year: \_\_\_\_\_

Previous Benefits used: \_\_\_\_\_

Ins. Pays: monthly / quarterly / 1 time Pre-authorization required: Y/N