AAC ORTHODONTICS
ADULT ADOLESCENT CHILD

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Member American Association of Orthodontists

GOLD+ INVISALIGN PROVIDER

INSURANCE INFORMATION

*PATIENT NAME: _____

BIRTHDATE: _____/_____/_____

*EMPLOYEE/SUBSCRIBER NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE#: _____

BIRTHDAY: _____/_____/_____

SOCIAL Security #: _____

*EMPLOYER NAME: _____

*INSURANCE NAME: _____

*DENTAL CLAIMS FILING ADDRESS: _____

CITY/STATE/ZIP: _____

*INSURANCE PHONE #: ( ) _____ - _____

*INSURED IDENTIFICATION#: _____

*GROUP AND/OR PLAN #: _____

FILING INSTRUCTIONS & RELEASE

1. Information for insurance is required by the placement date to insure timely filing.
2. In the event that additional correspondence is needed there will be a charge of $20 for each piece requested beyond the normal insurance claim forms.
3. It is up to the insured to make sure the insurance is being resubmitted either Monthly or quarterly based on the companies provisions.

I hereby authorize A.A.C. Orthodontics to release any information regarding services rendered by them. By signing below I am authorizing the use of my signature on all claim forms that are submitted and understand that I am financially responsible for the fees for service rendered regardless, of insurance benefits.

_____ INSURED SIGNATURE

_____ DATE

312 E. U.S. 30
SCHERERVILLE, IN 46375
(219) 322-8008
Fax (219) 322-7779

8165 CALUMET AVENUE
MUNSTER, IN46321
(219) 836-0888
Fax (219) 836-8855

2262 W. MORTHLAND DRIVE
(US HIGHWAY 30)
VALPARAISO, IN 46385
(219) 531-0544

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