Mason, Faith & Hoscheit DDS, LTD

INSURANCE INFORMATION

(This must be filled out before we can file your insurance. Please print clearly and complete all information.)

EMPLOYEE INFORMATION	
Employee Name (Policy holder)	
Employee Social Security # or member ID # *Information is required or claim cannot be processed*	
Employee Birth Date	
Employee Address	
City, State, Zip	

EMPLOYER INFORMATION	
Employer Name	

INSURANCE COMPANY INFORMATION	
Insurance Company Name	
Insurance Company Address	
City, State, Zip	
Insurance Phone Number	
Insurance Group Number	
Insurance Group Name (if different than Employer Name)	

OTHER FAMILY MEMBERS COVERED BY THIS INSURANCE PLAN				
Spouse's Name				
Spouse's Birth Date		Spouse's Social Security #		
Child's Name		Child's Birth Date		
Child's Name		Child's Birth Date		
Child's Name		Child's Birth Date		
Child's Name		Child's Birth Date		
Is your family covered by another dental plan? If yes, please fill out an additional form.			☐ yes	☐ no

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Mason, Faith & Hoscheit DDS, LTD.

Subscriber Signature		**Date**	

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