eng orthodontics
Dr. Albert Eng & Associates

DENTAL INSURANCE INFORMATION

Insured's Name _____ DOB_____/_____/_____

Medicaid ID# _____

Do you have dual coverage? Yes _____ No ____ (**If yes, please complete information below**.)

Insurance Company Name _____

Insurance Company Address_____

Employer Name _____ Phone _____

Group No. _____ Subscriber ID No. _____

Policy Holder Name _____

Policy Holder SSN _____-_____-_____ Policy DOB _____/_____/_____

We are committed to providing you with the best possible care. If you have dental insurance, we are eager to help you receive your maximum allowable benefits. To achieve these goals, we need your assistance and understanding of our payment policy.

After the exam with the doctor is completed, we will submit a prior authorization to the insurance. It is not guaranteed that the patient will be approved for treatment as they must meet strict criteria for the insurance to consider treatment.

If the patient is approved for treatment, Medicaid insurance does not pay for treatment up front for Comprehensive treatment. An initial claim will be submitted the day that the patient starts treatment; thereafter, claims will be submitted every 5-6 months correlating with an appointment for a total of 5 payments throughout treatment. Final payment being the day all orthodontic appliances are removed. If your insurance terminates during treatment or your insurance plan changes to CHP+ you will be responsible for the remaining balance on your account and payment arrangements will need to be made.

We must emphasize that as a dental care provider, our relationship is with our patients and their families and not with their respective insurance companies. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payments of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you!

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

Signature: _____ Date _____/_____/_____