STEPHEN L. GODWIN, DMD, DMSc, LLC
SPECIALIST IN ORTHODONTICS FOR ADULTS AND CHILDREN
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CHANGE OF MEDICAL INSURANCE FORM

This form must be completed in full to process your insurance benefit*

Today's Date:_____

Patient's Name:_____ **Birthdate:**_____

Patient's Address:_____ **Phone:**_____

Old Medical Insurance Co. Name:_____

Policy Termination Date:_____

New Medical Insurance Co. Name:_____

Effective Date of Policy:_____

Insurance Address:_____

Phone:_____ **Group #:**_____ **Policy #:**_____

Policy Owner's Name:_____ **SS#:**_____

Relationship to Patient:_____ **Policy Holder's DOB:**_____/_____/_____

Policy Owner's Address:_____ **Phone:**_____

Employer:_____ **Employer's Address:**_____

I certify that the information I have provided is true and correct to the best of my knowledge. I authorize Bel Air Orthodontics to apply for health insurance benefits on my behalf. I understand by providing the above information does not guarantee payment from the new insurance carrier.

_____

Signature of Legal Guardian or Policy Holder **Date**

-- TO BE COMPLETED BY OFFICE --

MEDICAL INSURANCE VERIFICATION

Patient Name: _____ **Birthdate:** _____

Address: _____ **Phone:** _____

Lifetime Maximum: _____ **ind. or fam. (circle)** **Payable:** _____ **%**

Used to date: _____ **Waiting Period? Y/N, If yes:** _____

Ded: _____ **Paid yet?** _____

Age Restrictions: _____ **Who: Employee, Spouse, Dependents (circle)**

Disbursement: _____ **% IP**

AUTO or RE-SUBMIT (circle)

MONTHLY or QTRLY or SEMI-ANNUALLY or ANNUALLY (circle)

_____

_____

_____

Records thru Ortho LTM or Preventative:

Pan (CDT code D0330): _____ **CEPH (CDT code D0340):** _____

Photos (CDT code D0350): _____ **Models (CDT code D0470):** _____

COVER WORK IN PROGRESS? Y/N

_____

_____

_____

_____

_____

_____

Staff Name & Date: _____ **Ins. Rep. Name:** _____