Massari-Wilson Family Dentistry

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AUTHORIZATION TO FILE CLAIMS/SIGNATURE ON FILE

Employee's Name: _____

Employee's last four of SS#__ __ __ __ Employee's Date of Birth: ___/___/____

Employee's Current Address: _____

Patient's we are authorized to file employee's insurance on:

1. _____ Date of Birth: _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____

I authorize payment to be paid directly to the provider. Y___ N___

Employee's Signature: _____

RELEASE AUTHORIZATION

I authorize the release of any information requested by my insurance company, employer, hospital, physician or pharmacy. A photostatic copy of this authorization is considered as effective and valid as the original.

Employee's Signature: _____Date:_____

****We require **yearly**, that you bring a copy of your **dental (not medical) insurance card** and/or a **claim form** from your insurance company with the address, phone #, and group # to file insurance. ****Form should be completed by the insured and signed. Thank you!