American Association of Orthodontists

Date:

CONFIRMATION OF ELIGIBILITY FOR ORTHODONTIC SERVICES

In order for the insured to know and better understand his or her insurance coverage, the following form is being provided. Your cooperation in its completion will be appreciated by the insured and the orthodontist.

TO BE FILLED OUT BY THE PATIENT

Name of Patient: _____ Age: _____

Name of Insured: _____ Relationship: _____

Employer and/or Union: _____

S.S.N./S.I.N. of Insured: _____

TO BE FILLED OUT BY THE INSURED'S EMPLOYEE BENEFITS DEPARTMENT

Eligibility: ☐ Yes

☐ No If not eligible, are X-rays or Diagnostic Procedures Covered? ☐Yes ☐No

Contract Identification: _____

Contract Number: _____

Benefits under this program are subject to the following:

Deductible Amount: _____

Co-Insurance Factor: _____

Maximum Orthodontic Benefits: _____

Have orthodontic benefits been reduced by previous treatment? ☐Yes ☐No

Total fees for previous treatment: _____

Total remaining benefits: _____

Is payment guaranteed throughout treatment, once initiated, irrespective of changes in status of insured?

☐Yes ☐No

Other exclusions which may affect coverage: _____

Signed: _____ Date: _____

Title: _____

PLEASE RETURN COMPLETED FORM TO INSURED