DAVID L. MCINTOSH, D.M.D.

Please **call your insurance company** to obtain answers to all the following questions, and kindly bring this form with you to your appointment or email to us at: info@mcintoshortho.com, or fax: 407-644-5090. As a courtesy, we are happy to submit charges to your insurance company. **This information is vital in order for us to accept payments, otherwise we will have the insurance company reimburse you with any benefits.** Thank you very much for your assistance!

INSURANCE INQUIRY FORM

Patient's name: ____ DOB: ______________ Age: _______

Subscriber's name: ______________________________________ DOB: ______________________

SS# or Subscriber ID #: __________________________________ Employer: ______________________

Insurance company: ______________________________________ Phone #: _____-_________________

Group name: ____ Group #: ________________________

Claim mailing address: ____

Please inform your insurance company Dr. McIntosh is an

"OUT OF NETWORK" provider and ASK THE FOLLOWING QUESTIONS………

Is there Orthodontic coverage? No Yes If so, Effective Date: ___________

Must we go to a "Network" Orthodontist? No Yes

Waiting period for benefits? No Yes If so, ____________ months

Is there an age limit? No Yes If so, ____________ years

Is THIS patient currently eligible? No Yes

May I assign benefits payable to an "out of network" orthodontist? Yes No

(If currently in treatment) Will you cover orthodontics already in progress? Yes No

Maximum benefit $ _______________ Lifetime or Annual Used to date (if any) $ _______________

Deductible (if any) $ ______________ Lifetime or Annual Applied to date (if any) $ _____________

At what percentage will payments be made? Initial payment______ % Monthly payments_______%

Is the initial payment based on the: Treatment fee **OR** Orthodontic lifetime maximum (please circle one)

File claims periodically? Monthly or Quarterly **OR** Automatic payment? Monthly or Quarterly

Do you accept fax submission? No Yes If so, # ________________________________

Name of person spoken to: ______________________________________ Date: __________________

Confirmed by _______________