
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 you may fax: Maitland fax 407-644-5090 Winter Park fax 407-671-2237. 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 #: 1-800- _____

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 Orthodontic lifetime maximum

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

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

Name of person spoken to: _____ Date: _____

For Office Use

Information confirmed by (initials): _____

Entered in computer by (initials): _____