Dental Insurance Coverage:

Subscriber Name _____

Subscriber D.O.B _____/_____/_____

Address _____

_____

Subscriber S.S #_____

Insurance Carrier: _____

Employer _____

Subscriber ID _____

Group ID _____

Claims Mailing Address & Payor ID _____

_____

_____

DENTAL COVERAGE IS NOT A GUARANTEE OF PAYMENT. YOU WILL BE RESPONSIBLE FOR ANY BALANCE NOT COVERED UNDER YOUR INSURANCE. WE CANNOT BILL ANY NYS OF HEALTH, COMMUNITY, CHILD HEALTH PLUS/ FAMILY HEALTH PLUS OR MEDICAID PLANS.