

Insurance Benefit Confirmation

Brian Reising, DDS, MS
Orthodontic Specialist

traditional and ceramic / clear braces
implant assisted orthodontics
hidden / lingual braces
surgical orthodontics
invisalign



Please mark one of the following boxes and complete any necessary information for the section selected. If treatment is elected, the section selected must be completed in its entirety in order for Reising Orthodontics to submit a claim and accept monies directly from the insurance company. If not completed in its entirety by the start of treatment, the insurance company will pay the subscriber/policy holder directly. Please note: We are not contracted with any insurance company. We file one claim to one insurance company and accept monies directly from one insurance company as a courtesy to our patients. If for any reason your insurance company changes throughout the course of treatment, the remaining balance will be transferred to the responsible party and the new insurance company will pay the subscriber/policy holder directly. You are essentially responsible for any claims not paid within 45 days of the dated submitted. By signing below, I understand the above statement.

Signature: _____

There is no dental/orthodontic coverage for this patient.

Signature: _____

I would like the insurance company to pay the subscriber/policy holder directly (ie: responsible party, patient). Please submit a claim for orthodontic treatment and continuation of treatment forms to the insurance company listed below. Please note: Certain insurance companies (Delta Dental of MN & Federal BCBS for sure) will only pay the subscriber/policy holder directly.

Signature: _____

I have orthodontic coverage. Please submit a claim for orthodontic treatment and continuation of treatment forms to the insurance company listed below. By signing below, I authorize Reising Orthodontics to receive direct payment of orthodontic benefits when filing orthodontic claims.

Signature: _____

To be completed by subscriber/policy holder:

Patient's Name		Patient's DOB	
Insurance Company Name		Insurance Company Phone #	
Insurance Company Claim Address1		Insurance Company Claim Address2	
Policy Holder's Name		Policy Holder's DOB	
Policy Holder's Member ID		Policy Holder's SSN	
Policy Holder's Group #		Policy Holder's Employer	
What is the lifetime max for orthodontics?		Have any of the orthodontic benefits been used?	