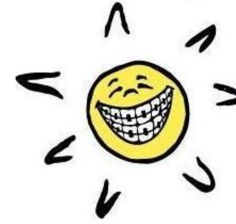

INSURANCE VERIFICATION FORM

To serve you best and to ensure insurance benefit information is available for your visit,
PLEASE RETURN THIS COMPLETED FORM 5 DAYS PRIOR TO YOUR APPOINTMENT.
Via: E-mail *Billing@DrLawrence.com*; Fax (440) 974-0305 or by Mail.

Pretreatment information from your insurance company is not always reliable.
Please contact your insurance company to verify information the insurance company provides our office.

DENTAL INSURANCE INFORMATION

Patient Name____ Patient DOB______/______/______

Subscriber Name ____________________________________ Subscriber DOB ______/______/______

Subscriber SSN # __________-__________-__________ Subscriber ID # ________________________

Insured Person: ☐ Mother ☐ Step-Mother ☐ Father ☐ Step-Father ☐ Self ☐ Spouse

Employer ____

Insurance Company ____

Claims Mailing Address____

____

Insurance Co. Phone # ____

Group #______________________________________ Payer ID __________________________________

***If you have a second insurance, please fill out a form for each**

OFFICE USE ONLY ________PRIMARY INSURANCE ________SECONDARY INSURANCE

Ortho ________% Max $________ Used $________ Remaining $________

Deduct________ MET - *YES* *NO* Age Limit ________ Student Age ________

Effective Date _________ Bill - *Monthly* *Quarterly* Automated *Yes* *No*

TMD Coverage *YES* *NO* $________________

Waiting Period *Yes* *No* Pay In Progress *Yes* *No* Assignment *Yes* *No*

Verified By ____________________ Rep ____________________________Date ______/______/______