

# INSURANCE INFORMATION FOR STATE PATIENT

(Please Print)

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Responsible Party Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Responsible Party Social Security #: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_

Subscriber/ Client ID: \_\_\_\_\_ Group Number: \_\_\_\_\_

***Is the patient covered by a secondary insurance? Yes / No***

Secondary Insurance Co.: \_\_\_\_\_

Secondary Subscribers Name: \_\_\_\_\_ Subscriber/Client ID: \_\_\_\_\_

Secondary Social Security No.: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Parent's Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Employer's Phone Number: \_\_\_\_\_

.....  
**AUTHORIZATION TO RELEASE INFORMATION** - I hereby authorize any Dentist, Physician, Hospital, Pharmacy, Insurance Company, Employer or Organization to release any information regarding the medical or dental history, treatment or benefits payable for this claim to The Plan Administrator or its authorized agent for the purpose of validating and determining benefits payable in connection with this claim. Data may be extracted for statistical, audit and verification purposes. I understand that I may request to receive a copy of this authorization:

\_\_\_\_\_  
Signature Print Date

.....  
**AUTHORIZATION TO PAY BENEFITS TO DENTIST** - I hereby authorize payment directly to the above named Dentist of the Dental Benefits otherwise payable to me.

\_\_\_\_\_  
Signature Print Date

.....  
**CERTIFICATION** - I certify that the foregoing information is true and correct.

\_\_\_\_\_  
Signature Print Date