Insurance Release Form

Primary Insurance Information

Subscriber Name_____ Soc. Security No._____

Subscriber's Employer_____ Date of Birth_____

Insurance Company_____ Group No. _____

Insurance Company Phone No_____

Secondary Insurance Information

Subscriber Name_____ Soc. Security No._____

Subscriber's Employer_____ Date of Birth_____

Insurance Company_____ Group No. _____

Insurance Company Phone No_____

Additional Insurance Information

Subscriber Name_____ Soc. Security No._____

Subscriber's Employer_____ Date of Birth_____

Insurance Company_____ Group No. _____

Insurance Company Phone No_____

INSURANCE AUTHORIZATION

I hereby authorize payment directly to the below named orthodontist for the group insurance benefits otherwise payable to me. I also authorize the release of any information needed to process this claim.

_____

Primary Insured Signature

I hereby authorize payment directly to the below named orthodontist for the group insurance benefits otherwise payable to me. I also authorize the release of any information needed to process this claim.

_____

Additional Insured Signature

I hereby authorize payment directly to the below named orthodontist for the group insurance benefits otherwise payable to me. I also authorize the release of any information needed to process this claim.

_____

Secondary Insured Signature

Orthodontist Name:
Jay P. Zuroff DDS, MSD, PS

Mailing Address:
3321 W. Kennewick Ave., Ste 260
Kennewick, WA 99336

Phone Number: (509)735-7772

Orthodontist TIN: 91-1604033

Orthodontist License No.: 6305

I hereby certify that the procedures as indicated by the date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

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Signature of Orthodontist