

## **Attention Insured Patient,**

In order to submit claims accurately, the following are needed:

1. **We need all necessary information on the policyholder.**
2. **Information does need to be verified by the insurance company.**

### **NOTE:**

Information provided by the insurance company **IS NOT A GUARANTEE OF BENEFITS**, only an **estimation**. Please review your policy book so there are no misunderstandings. If you do not have a policy book, contact your human resource office.

You, the patient, are responsible for your own policy, **we are third party billing only**, and given minimal information by your insurance company.

***You are responsible for all co-pays at time of service, and any balances that may occur after the insurance has paid.***

### **OUR GOAL:**

To give you the best estimate possible with the information given to us by your insurance. **Until the insurance company receives the actual CLAIM, it remains an ESTIMATE and not a GUARANTEE.** **TREATMENT PLANS AVAILABLE.**

By signing below,

I authorize direct payment of the insurance benefits to Unique Dental Care and its' associate doctors, for treatment rendered to me and/or my child/children.

I have read and understand the above policies.

Patient/Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_