



Hatcher Orthodontics

William R. Hatcher, D.D.S., M.S., P.C.

Diplomate, American Board of Orthodontics

Thomas D. Hawley, D.D.S., M.S.

Diplomate, American Board of Orthodontics

INSURANCE INQUIRY FORM

Please provide us with the following information (**printed in bold**) so that we may check on your insurance when you visit our office. If possible, bring your insurance card with you to this appointment. As a courtesy, we are happy to submit charges to your insurance company. Please understand this is not a guarantee of benefits. Thank you very much for your assistance!

PRIMARY INSURANCE:

Patient's name: _____ **DOB:** _____ **AGE:** _____

Subscriber's name: _____ **DOB:** _____ **SS #:** _____

Subscriber's address: _____

Employer: _____ **I.D. Number (if different than SS#):** _____

Insurance company: _____ **Group #:** _____

Ins. Co. Mailing Address: _____

_____ **Ins. Co. Phone #:** _____

Is there orthodontic coverage? No Yes If yes, Effective Date: _____

Must we go to a "Network" Orthodontist? No Yes

Waiting period for benefits? No Yes If yes, _____ months

Is there an age limit? No Yes If yes, _____ years

Is THIS patient currently eligible? No Yes

May I assign benefits payable to an "out of network" orthodontist? Yes No

(If currently in treatment) Will you cover orthodontics already in progress? Yes No

Maximum benefit \$ _____ Lifetime or Annual Used to date (if any) \$ _____

Deductible (if any) \$ _____ Lifetime or Annual Applied to date (if any) \$ _____

% paid: _____ % (of usual/customary/reasonable) Automatic Payment? Monthly or Quarterly

For Office Use: Name of person you spoke with: _____ Date: _____

SECONDARY INSURANCE:

Patient's name: _____ **DOB:** _____ **AGE:** _____

Subscriber's name: _____ **DOB:** _____ **SS #:** _____

Subscriber's address: _____

Employer: _____ **I.D. Number (if different than SS#):** _____

Insurance company: _____ **Group #:** _____

Ins. Co. Mailing Address: _____

_____ **Ins. Co. Phone #:** _____

Is there orthodontic coverage? No Yes If yes, Effective Date: _____

Must we go to a "Network" Orthodontist? No Yes

Waiting period for benefits? No Yes If yes, _____ months

Is there an age limit? No Yes If yes, _____ years

Is THIS patient currently eligible? No Yes

May I assign benefits payable to an "out of network" orthodontist? Yes No

(If currently in treatment) Will you cover orthodontics already in progress? Yes No

Maximum benefit \$ _____ Lifetime or Annual Used to date (if any) \$ _____

Deductible (if any) \$ _____ Lifetime or Annual Applied to date (if any) \$ _____

% paid: _____ % (of usual/customary/reasonable) Automatic Payment? Monthly or Quarterly

For Office Use: Name of person you spoke with: _____ Date: _____