# *D. Michael Ellis, D.D.S.*
# *Meghan Lindgren, DDS*
**ORTHODONTICS**

## *Insurance Coverage Form*

**Patient Name:** _____ **DOB:** _____

### *Insurance Company Information*

**Name of Company:** _____

**Phone # (Benefits/Eligibility)** _____

**Claims Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

### *Subscriber Information*

**Name of Insured:** _____

**DOB:** _____

**Policy ID# or SS#** _____

*For Office Use Only*

**Contact:** _____ **Date:** _____

**Effective Date:** _____ **Benefit:** _____**% Lifetime Max:** _____

**Used:** _____ **Remaining:** _____

**Deductible/ Copay:** _____ **Waiting Period:** _____

**Payment Schedule: AM S¼ A¼ Other:** _____

**Covers: DEP Age Limit:** _____ **PH/ SP Coverage: Y/N**

**WIP:** _____ **Medically Necessary:** _____