Dr. Harvey Levy & Associates

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INSURANCE VERIFICATION FORM

Only fill out this form if you have commercial dental insurance.

Patient Name: _____* _____* ____ _____
Last First MI Preferred Name

DOB: * _____

Primary Dental Insurance

Name of Insured: _____* _____* ____
Last First MI

Insured's Birth Date:* _____ **ID #:*** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ ____ _____-____
City State Zip Code

Insured's Employer Name:* _____

Employer Address: _____ _____
Address 1 Address 2

_____ ____ _____-____
City State Zip Code

Patient's relationship to insured:* ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:* _____

Insurance Address: _____ _____
Address 1 Address 2

_____ ____ _____-____
City State Zip Code

Do you have Secondary Dental Insurance? * ◯ Yes ◯ No

If yes, please complete the following:

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ ____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insurance Authorization:

☐ * **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

If filling out a paper copy of this form, please sign:

_____

_____

_____

Response Date: _____