American Association of Orthodontists

My Life. My Smile. My Orthodontist.®

CONFIRMATION OF ELIGIBILITY FOR ORTHODONTIC SERVICES

In order for the insured to know and better understand his or her insurance coverage, the following form is being provided. Your cooperation in its completion will be appreciated by the insured and the orthodontist.

TO BE FILLED OUT BY PATIENT

Date ____________

Name of Patient ____Age __________

Name of Insured ____Relationship _________________

Employer and/or Union ____

S.S.N./S.I.N. of Insured ________ -________ - ________

TO BE FILLED BY THE INSURED'S EMPLOYEE BENEFITS DEPARTMENT

Eligibility ☐Yes

☐No If not eligible, are X-rays or Diagnostic Procedures Covered? ☐Yes ☐ No

Contract Identification ____

Contract Number _________________________________

Benefits under this program are subject to the following:

Deductible Amount ___________________________

Coinsurance Factor __________________________

Maximum Orthodontic Benefits ________________

Have orthodontic benefits been reduced by previous treatment? ☐Yes ☐ No

Total fees for previous treatment _______________

Total remaining benefits ______________________

Is payment guaranteed throughout treatment, once initiated, irrespective of changes in status of insured?

☐Yes ☐ No

Other exclusions which may affect coverage ____

Signed: ____ Date: _______________

Title: ____

PLEASE RETURN COMPLETED FORM TO INSURED

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