MORGAN CROSSING
DENTAL

Insurance Assignment

Our office is pleased to accept your insurance assignment as a courtesy to you. Instead of requiring full payment from you at the time of treatment and having you wait for reimbursement from your insurance company, we can bill your insurance directly.

The following are our policies governing insurance claims:

I. All patients must sign an "Authorization to Pay Dentist" form or any other necessary documents required for assignment by their insurance company.

2. All patients must pay their portion of fees on the day treatment is rendered unless previous financial arrangements have been made.

3. The office must be informed as soon as possible if there is any change to insurance information. If we are informed at the time of the appointment insurance confirmation may not be possible, therefore you will be required to pay the full cost of the appointment and wait for reimbursement.

4. Insurance companies should pay us within 60 days. If payment has not been received within 90 days, we request that the balance owing be paid by the patient who can then be directly reimbursed by the insurance provider.

5. It is the responsibility of the patient to ensure our office has all the necessary information needed to attain an explanation of benefits. Our office cannot guarantee that your insurance will pay for all necessary treatment. We will perform our routine insurance billing procedures after your coverage has been verified.
If for some reason your insurance claim is denied, you will be responsible for any remaining balance.

6. Our office will not enter into a dispute with your insurance company over your claim. This is your responsibility and obligation.

7. All non- assignment policy holders must paid full balance when treatment is rendered. Our office will happily submit the claim on your behalf for reimbursement.

Authorization to Pay Dentist:

I _____ authorize that the dental office may send claims, pre - authorizations and/or other dental info to my insurance company electronically through their secure dental system. I hereby assign my benefits from any claims submitted to be paid to ***Morgan Crossing Dental*** and authorize payment directly to them and agree to all policies stated above.

Signature _____ Date _____
*This signature confirms you have read all our office policy and agree to them

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