ORTHODONTIC BILLING AUTHORIZATION FOR INSURANCE

R.A. McFarland, D.D.S, M.S.
651 Crosstimbers Road, #100
Flower Mound, Texas 75028
(972) 221-2515

Tax ID: 75-1505908
Lic #: 9807

Patient's Name: ______________________________

Patient's Date of Birth: ______________________________

Employee's Name: ______________________________

Relationship to patient: ____________________ Employee's Date of Birth: ____________

Employee's Address: ______________________________

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Employee's ID or SSN: ______________________________

Name of Employer: ______________________________

Complete Name, Address, and Telephone of Insurance Company

______________________________ Policy # ____________

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Is there other insurance for this patient?

If so, please give complete name, address, telephone number of second insurance carrier, policy number, name of insured, SSN or ID number.

****IMPORTANT** TO ASSIST US WITH THE ELECTRONIC FILING OF INSURANCE CLAIMS, THE ABOVE INFORMATION IS MANDATORY. ANY FIELD LEFT BLANK WILL CAUSE A CLAIM TO BE REJECTED.**

I authorize payment of this claim to be made directly to Dr. McFarland

______________________________ ____________________

Signature of Insured/Authorized Person Date

I authorize the release of any information relating to this claim

______________________________ ____________________

Signature of Insured/Authorized Person Date