INSURANCE BENEFITS VERIFICATION

CLEAR

Dental Office/Dentist

DATE of APPOINTMENT:

Anesthesiologist: Bonnie Song, M.D.
NW Mobile Anesthesia

PATIENT NAME (+MI): DOB: GENDER:

Comments / Clinical

INSURANCE COMPANY: CUST. SERVICE (800):

EFFECTIVE DATE:

BILLING ADDRESS:

SUBSCRIBER POLICY #:

SUBSCRIBER/Guarantor: GROUP #:

RELATION TO PATIENT: GUARANTOR DOB:

PATIENT INFORMATION:

GUARANTOR SS #

ADDRESS (+zip):

Home Phone # Emergency Contact

Cell Phone # Phone #:

FOR OFFICIAL USE ONLY

Talked to:	***Date:***	***Time:***
OUT OF NETWORK BENEFITS		
ANESTHESIA LIMIT/MAX		
DEDUCTIBLE /AMOUNT SATISFIED		
COPAY		
% COVERED		

AMOUNT USED:

CLINICAL NOTES NEEDED? ☐Yes ☐No fax no:

ANESTHESIA AUTH NEEDED? ☐Yes ☐No fax no:

Patient Responsibility:

PATIENT UNDERSTANDING AND AGREEMENT:

The information above provided by the patient's insurance company to Dr. Bonnie Song, M.D., is not a guarantee of payment. The patient/guarantor may be responsible for the charges misquoted or not disclosed by the insurance. By signing below, patient understands his/her insurance benefits and limitations and agrees to payment based on insurance(s) response determining patient financial portions for general anesthesia.

Guarantor/Parent signature: _____Date_____