Secondary Insurance Responsibility

Date_____

Patient Information

Patient's Name_____
First M.I. Last

Address_____ City, State, Zip_____

Secondary Insurance

Policy Holder's Name _____ _____ DOB___/____/_____
Relationship to patient

Insurance Company _____ ID # _____ Group #_____

Insurance Company Phone #_____

Coordination of benefits is processed by: ☐ Birth date ☐ Court Order

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Verification: Please initial

I have, within the last 24 hours, verified the correct billing order of my insurances and have communicated that information to Kutsch and Renyer Family and Cosmetic Dentistry. _____ initial

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Authorization: All Patients or Guardians Must Sign

X_____ _____
Patient or Guardian's Signature Date

Additional Comments: