Dental Benefit Assignment Form

Covered Person:

Last name	**First name**	**DOB**

Address	**Member ID#**

NOTICE: I, the covered person, acknowledge that I have been informed of and understand the following:

- This provider has not joined my dental carrier's network and therefore, is a non-participating provider.
- Non-participating providers may charge for non-covered dental services and may also charge for any part of the cost of a covered dental service that my dental carrier does not reimburse.
- This dental benefit assignment is optional.
- A photocopy of this benefit assignment is as valid as the original.
- This benefit assignment will remain in effect until I revoke it in writing and provide a copy to my dental carrier.
- If a credit occurs due to overpayment, my provider shall give me notice within thirty (30) days and if I request a refund, shall refund the credit within thirty (30) days of my request.
- If under this benefit assignment my provider first receives a payment from me and then receives a payment from my dental carrier, my provider shall refund me within thirty (30) days, unless I agree otherwise in writing.

RELEASE OF INFORMATION: On behalf of myself and my dependents, I authorize **[Provider]** to disclose and release to my dental carrier **[Dental Carrier Name]**, as applicable, any medical and treatment information needed for payment purposes for dental services rendered. I authorize use of this form for the release of information needed to process claims to **[Insurer/Carrier Name]** and its authorized agents. I authorize my provider to act as my agent in helping obtain payment from my dental carrier.

ASSIGNMENT OF BENEFITS: I assign all payments, rights, and claims for all medical, dental, and surgical benefits or reimbursement of claims, costs, and expenses allowable under my dental carrier's plan(s) directly to my provider for services performed. I understand I will receive a statement for any balance due by me or my dependents and I agree to make full payment upon receipt of the statement after my dental carrier has met its obligation.

AGREEMENT OF RESPONSIBILITY: I understand that **COPAYMENT IS DUE AT THE TIME OF SERVICE** (my provider may also collect coinsurance and deductibles at the time of service). I understand I am financially responsible for charges not covered by my dental carrier. I also agree to pay any outstanding balance as well as attorney fees and costs to **[Provider Name]** if my provider must refer this matter to collection.

Covered Person's signature	**Print name**	**Date**

Provider signature	**Print name**	**Date**