DENTAL ANESTHESIA ASSOCIATES

PRIVATE INSURANCE REIMBURSEMENT FORM

Patient Name: _____ Circle: M / F Patient Birthdate:_____

Insured /Subscriber NAME: _____ Insured ID/SS#: _____

Insured Birthdate: _____ Email: _____

Insured Address: _____

_____

Dental Insurance Name AND Address: _____

_____

_____

Amount Paid to Anesthesiologist: _____ Date of Service: _____

WE DO NOT BILL MEDICAL INSURANCE

Insurance benefits are between you and your insurance company. We are not "preferred" providers for any insurance carrier. By signing this form, you acknowledge that you will NOT receive the benefit of the TRICARE Hold Harmless Policy if TRICARE is your insurance provider. Please provide us with your DENTAL billing information. We do NOT preauthorize anesthesia services to your insurance company on your behalf. Anesthesia fees are due at the time of your visit. If your carrier reimburses- the check will be sent to you directly from them.

Billing codes are D9222 first 15 minutes and D9223 each additional 15 minutes or any part thereof.

Authorization to bill insurance:

Insured Signature: _____ Date: _____

Please return completed form to:
Cynthia Teselle
DentalAnesthesiaAssoc@gmail.com

O 858.414.1293
F 858.430.4542
E dentalanesthesiaassoc@gmail.com