Dental Insurance Claim Coordination of Benefits Form

Patient Information

Full Name

Date of Birth

Patient ID/Member #

Subscriber Name

Relationship to Subscriber

Primary Insurance Information

Insurance Company Name

Group #

Policy #

Effective Date

Termination Date

Secondary Insurance Information

Insurance Company Name

Group #

Policy #

Effective Date

Termination Date

Other Coverage Information

Is patient covered by another dental plan?

If yes, provide details

Signature & Authorization

Signature

Date