

**LYNDHURST DENTAL CENTRE**

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**Electronic Claim Submission Enrollment Form**

**Primary Policy Holder Insurance Information**

Name of Policy Holder _____		Policy Holder Birthdate _____	
Names of family members covered under this policy...			
1. _____	Relationship to Policy Holder _____		
2. _____	Relationship to Policy Holder _____		
3. _____	Relationship to Policy Holder _____		
4. _____	Relationship to Policy Holder _____		
5. _____	Relationship to Policy Holder _____		
6. _____	Relationship to Policy Holder _____		
Name of Insurance Company _____			
Policy Number _____		ID or Certificate Number _____	
Division Number (if applicable) _____			

Do you have coverage with more than one insurance company? YES \_\_\_\_\_ NO \_\_\_\_\_

**If yes,** please complete the following...

**Secondary Policy Holder Insurance Information**

Name of Policy Holder _____		Policy Holder Birthdate _____	
Names of family members covered under this policy...			
1. _____	Relationship to Policy Holder _____		
2. _____	Relationship to Policy Holder _____		
3. _____	Relationship to Policy Holder _____		
4. _____	Relationship to Policy Holder _____		
5. _____	Relationship to Policy Holder _____		
6. _____	Relationship to Policy Holder _____		
Name of Insurance Company _____			
Policy Number _____		ID or Certificate Number _____	
Division Number (if applicable) _____			

**CONSENT FORM**

I hereby authorize release, to my Insuring Company Plan Administrator, the information contained in claims submitted electronically.  _____ Signature of Patient or Parent/Guardian
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