

INSURANCE POLICY

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OUR OFFICE IS PLEASED TO FILE YOUR DENTAL INSURANCE AS A COURTESY TO YOU. IF YOU HAVE DENTAL INSURANCE AND WOULD LIKE FOR OUR OFFICE TO FILE YOUR DENTAL CLAIMS FOR YOU, PLEASE READ THE FOLLOWING POLICY INFORMATION AND INITIAL WHERE INDICATED. YOUR INSURANCE CLAIMS WILL NOT BE FILED UNLESS YOU ACCEPT THE TERMS OF OUR INSURANCE POLICY.

Scott P. Guice D.D.S., P.A. recognizes the patient’s need to maximize benefits and lower out-of-pocket costs. Therefore, as a *courtesy* to our patients we are happy to help you by filing your primary insurance. Our office is a CIGNA PPO provider, as well as, a Delta Dental Premier provider. We will not be responsible for insurance non-payment and/or exclusions determined by your insurance provider.

Please keep in mind that your insurance company has the following disclaimer regarding claims:
“THE FOLLOWING IS NOT A GUARANTEE OF PAYMENT. *FINAL CONFIRMATION OF BENEFITS WILL BE DETERMINED ONCE A CLAIM HAS BEEN RECEIVED.*”

Patient Initials: _____

All estimated portions not covered by insurance will be due in full at the time of service.

Our office will file a claim on your behalf. We will provide your insurance company with necessary x-rays and/or other written documentation to aid in their determination of benefits. The North Carolina Insurance Commission requires that an insurance company respond to a claim within thirty days. If your insurance company has not paid on the claim within 45 days, it is your responsibility to follow-up with them.

Patient Initials: _____

Your insurance policy is a contract between you, your employer and the insurance company, of which our office is not a party to. Regardless of whether or not the insurance pays on the claim, the responsibility to pay the account remains with you, the patient. We will not become involved in disputes between you and your insurance company (or employer) regarding deductibles, co-payments, “covered charges”, secondary insurance, “usual and customary” charges, etc., other than to supply factual information as necessary.

Patient Initials: _____

ATTENTION: Clicking the link below will prompt you to send this pdf form as an attachment using your default mail program.

1. Make sure you click the "Send Copy" option to ensure that we receive your form data.
2. Send this pdf copy to newpatients@lakenormandentistry.com