UNIVERSITY OF NEW ENGLAND
WESTBROOK COLLEGE
OF HEALTH PROFESSIONS
Department of Dental Hygiene

ASSIGNMENT OF BENEFITS AGREEMENT

The University of New England Dental Hygiene Clinic is pleased to accept your insurance assignment if you are in active status with Maine Care at the date of service. We will bill your dental carrier for the services performed as a courtesy, we will collect all co-pays and deductibles prior to treatment commencing. We will not be responsible for inaccurate estimates of co-pays or benefits, as payment by your dental carrier is not guaranteed. Ultimately any services denied or not paid by your insurance become patient responsibility. Dental insurance payments are generally received within 30 days from time of billing. If we have not received insurance payment at the end of 60 days, we reserve the right to bill the patient for the remaining balance and the patient may seek direct reimbursement from the insurance company. If you should have questions or concerns as to your dental coverage for a particular procedure, we recommend you either contact your dental carrier prior to your appointment or request a preauthorization of benefits be done prior to scheduling your next appointment.

Assignment of Benefits:

I hereby authorize assignment of all dental benefits for the services rendered by UNE-DH payable directly to the UNE- DH billing office. I also understand that UNE-DH has my permission to use any necessary medical or personal information as needed to process my dental claims or my dependents on my behalf.

I, _____ hereby understand that I am financially responsible for the entire amount of the services rendered should my insurance coverage be denied or additional co-payments should apply. I further understand that fees are due and payable on the date services are rendered or upon receipt of appropriate statement from UNE-DH. I acknowledge that the $5.00 X-ray transfer fee is not coved by MaineCare and that I will be responsible for the fee upfront as it will not be submitted to MaineCare for payment.

Responsible Party Signature _____ Date _____

Dental Insurance Information

Patient Name: _____ DOB: _____

Policy Holder Name: _____ DOB: _____

Employer: _____ Employee Tel. #: _____

Name of Insurance Company: _____ Insurance Tel. #: _____

Group Ins. #: _____ Policy Holder ID # or SS# _____

Mailing Address for Claims: _____

Please print other minor family members on patient account: _____

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