Insurance Information—Please Read!

The following information will be reviewed with you at your first visit. It must be completely filled out in order for us to give you the most accurate **estimation** of your benefits.

If you have medical insurance and would like to receive the maximum benefits available to you from your insurance company, it is important that **you** contact your insurance company **prior to your first visit in our office**. We certainly are happy to answer any insurance questions you may have, but please understand, MN Craniofacial Center can only assist you and cannot guarantee payment from your insurance company.

Please call your medical insurance company for the following information.

1. Do I have a deductible? Yes or No
   How much is the deductible? _________
   How much of the deductible has been met? ___________

2. Do I need a Prior Authorization for:
   A: DME (Durable Medical Equipment)? Yes or No
   (Give DME CODE **E0486-Oral Sleep Apnea Appliance** to your insurance representative. If that code does not work try **21110**)
   B: Physical Therapy Yes or No
   Fax number to send prior authorization: _____________________________

3. Do I have an office copayment for each visit? Yes or No

4. How much is the office copayment? _______________

5. Is a home sleep study covered? (Give code **95806**.) Yes or No
   What percentage of the fee do I owe? ___________________
   (MCC may recommend a home sleep study for follow-up purposes.)

6. What percentage of the fee do I pay for the following:
   A. X-Rays: _______________
   B. Office Visits: _______________
   C. DME (Durable Medical Equipment): ______________
   D. Physical Therapy: __________________

Date you called your insurance company___________________
Name of representative you spoke with ____________________

Repair Charges: Repair charges for broken oral appliances are the patient's responsibility to pay and the amount will vary, depending on the type of repair needed. Repair charges are not a covered service by your insurance company.

I have read and I understand my financial responsibility as stated above. I authorize direct payment of benefits from my insurance company to MN Craniofacial Center, P.C.

Signature of Insured, or of Responsible Party if Patient is a Minor:

Patient _____________________________________ Date: _____________
Witness __________________________________ Date: _____________

Patient Name: Appt date:
DOB: