Third-Party Payment Authorization Form for Dental Insurance

Patient Information

Full Name

Date of Birth

Phone Number

Email

Address

Insurance Policy Information

Insurance Company Name

Policy Number

Group Number (if applicable)

Policy Holder Name

Relationship to Patient

Third-Party Payee Information

Payee Name

Relationship to Patient

Payee Address

Phone Number

Email

Authorization

I hereby authorize the above-mentioned dental insurance provider to pay any benefits directly to the designated third-party payee for services rendered. I understand that I am responsible for any balance not covered by my insurance plan.

Additional Notes (if any)

Patient/Guardian Signature

Date

Third-Party Payee Signature

Date