Insurance Pre-Estimate Summary

YOUR PRACTICE NAME (on practice letterhead)

Patient: _____

Treatment: _____

Enclosed is a copy of the insurance pre-estimate that was recently received by our office. Your insurance company has provided the following estimate of benefits (not a guarantee):

Total estimated cost of treatment $ _____

Total estimated insurance benefit $ _____

Total estimated patient portion $ _____

Multiple Dental Plans:

Secondary dental plans typically pre-estimate treatment as if they are primary. Because of this, secondary pre-estimates may be unreliable. A secondary dental plan may reduce the amount it pays based on its coordination of benefits clause. If your secondary plan uses limited, non-duplication, maintenance, or integration of benefits, its pre-estimate may not accurately represent what will be paid on your claim. If you have multiple dental plans please contact your secondary insurance carrier to ask how it coordinates benefits.

Additional Information: _____

_____

_____

_____

Your estimated portion is due at the time of treatment. A pre-estimate is no guarantee of payment. Actual benefits paid will be subject to any applicable limitations or benefit maximums available at the time the claim is processed. Please note that dental treatment provided by another office during the current plan year can affect your available maximum of benefits. Please contact any member of our business team to assist you with any questions you may have regarding treatment, payment options, and/or to schedule an appointment.

We look forward to seeing you soon!

Staff Signature: _____ Date: _____

Patient Signature: _____ Date: _____