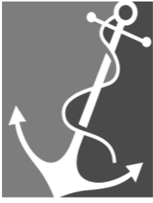
ANCHORAGE PEDIATRIC DENTISTRY

J. Brant Darby, DDS
Easte Warnick, DDS
4200 Lake Otis Parkway, Suite 102
Anchorage, AK 99508
P: (907) 562-1003 F: (907) 562-1006
www.anchoragepediatricdentistry.com

Insurance Billing & Payment Policy

Thank you for choosing us as your pediatric dental provider. We are committed to providing you with the highest quality dental care at an affordable rate. Recently, our patients' families have had questions regarding what is their financial responsibility and/or the insurance's responsibility for services rendered. Please read this policy, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance

We participate in multiple insurance plans including MetLife, Premera BCBS, Delta Dental/Moda Health, UCCI, & Medicaid/Denali KidCare. We will bill ALL insurance plans but if you are not insured by a plan that we are contracted with you will be responsible for any charges that exceed the contracted rates of your individual dental plan. Knowing your individual insurance plan benefits & frequency limitations is your responsibility. As a courtesy we do submit treatment estimates to your insurance policy prior to a scheduled appointment (with the exception of preventative or emergency appointments) but it is just an estimate. Your insurance company will determine benefits to be paid once the services have been submitted and the claim is processed. Please contact your insurance company with any questions you may have regarding your coverage or claims.

2. Co-payments & Deductibles

All ESTIMATED co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and/or deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment and/or deductible at each appointment.

3. Non-covered Services

Please be aware that some - perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by your insurance policy (including but not limited to Medicaid/DKC). By signing a treatment plan authorizing the work to be completed, you are accepting financial responsibility for those services.

4. Proof of Insurance

All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current/valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information at each appointment, you may be responsible for the balance of the claim.

5. Coverage Changes

If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

6. Claims Submission

We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may contact you directly if any additional information is necessary to process a submitted claim. It is your responsibility to comply with their request in a timely fashion. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. If your insurance does not pay your claim in 45 days, the balance will automatically be billed to you. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

7. Nonpayment

If your account is over 90 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and your family may be discharged from this practice. If this occurs, you will be notified by certified mail that you have 30 days to find alternative care. During that 30 day period, our doctor will only be able to treat you on an emergency basis.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our insurance billing and payment policy. Please let us know if you have any questions or concerns

____ ________________________

Signature of Responsibility Party DATE