

CONTINUING ORTHODONTIC BENEFIT FORM

ORTHODONTIST INFORMATION			
Orthodontic Office Name:		Orthodontist Name:	
Address:			
City:	State:	Zip:	
Phone:	EIN:		
SUBSCRIBER & PATIENT INFORMATION			
Subscriber Name:		Subscriber ID:	
Address:			
City:	State:	ZIP Code:	Phone:
Patient Name:	Date of Birth:	Relationship:	
CASE IN PROGRESS INFORMATION			
Banding Date:	Initial Treatment Term:	Remaining Months of Treatment:	
Name of Prior Dental Plan Carrier:		Prior Plan. Max. Allowance: \$	
Total Cost of Ortho. Case: \$	Agreed Upon Case Amount with Prior Carrier: \$		
Amount Paid to Date by Prior Carrier: \$	Amount Paid to Date by Patient: \$		
OTHER INSURANCE INFORMATION			
Does patient have other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, name of other dental carrier:	
Subscriber Name:	ID:	Date of Birth:	
Relationship to Patient:	Total Amount Paid by Carrier:		
ADDITIONAL INFORMATION			
Please be sure to attach copies of the following documents:			
<ol style="list-style-type: none"> 1. All Explanation of Payments/Benefits from other carriers 2. Dental Claim Form for service after 01/01/2025 with balance due 			
Return Form and All Documentation To: Nevada Dental Benefits, Ltd. Attn: Orthodontic Claims 6543 S. Las Vegas Blvd., 2 nd Floor Las Vegas, NV 89119			

For questions regarding this form, please call Nevada Dental Benefits, Ltd.'s Orthodontic Claim Department.

(702) 478-2014 or (866) 998-3944