Ashburn Farm Dental Arts
43330 Junction Plaza, Suite 122
Ashburn, VA 20147
(703) 729- 7900

Landmark Smile
5249 Duke Street, Suite 406
Alexandria, VA 22304
(703) 370-6800

IMPORTANT INSURANCE INFORMATION

All benefits provided by insurance companies are subject to limitations and exclusions.

We would like to make you aware of the process most insurance companies' use. Insurance companies often have what they call an "alternate benefit" clause. According to your particular insurance policy, they will downgrade procedures that fit the criteria.

Great examples of alternate benefits are in the case of fillings. When there are alternate plans of treatment, coverage is provided for the applicable percentage of the least costly, professionally satisfactory, course of treatment. This includes, but is not limited to, services such as composite resin fillings on molar teeth, in which case the benefits are based on the cost of the amalgam (silver) filling. When a downgrade is applied to fillings, insurance will pay the percentage of the silver filling rate, and the patient will be responsible for the difference between the white filling and the silver filling, plus their copay percentage.

This also includes crowns, fixed bridges and implants, in which case the benefits will be based on the cost of metal crowns, removable partial denture or fixed bridge. In most cases, we will send a pre-estimate to your insurance so we get a precise estimate of the dental procedures.

All treatment plans are individually prepared according to your insurance policy, your benefits and your recommended treatment. We will give you the best estimate with the information supplied by you and your insurance company. Insurance companies will not give a guarantee of benefits or payment as all dental work is subject to review. We will try to help you understand your benefits and coverage. But we encourage our patients to contact their insurance company if they have any questions regarding their benefits.

Ultimately, you are responsible for all financial obligations for your treatment.

Patient Name _____ Date: ____/_____/____

Guardian Name _____ Signature: _____