TUMWATER
FAMILY DENTISTRY

INSURANCE ELIGIBILITY FORM

RICHARD C. DOWNING, DDS
Your Family Dentist
6939 Littlerock Road SW, Suite B - Tumwater, WA 98512
(360) 352-0401

I, _____ hereby certify that I am eligible for dental coverage through

_____ as of _____
Insurance Provider Month/Day/Year

I understand that if the above is not true or if my insurance denies payment for any said reason under the terms of my Dental Subscriber Agreement, I am liable for all charges and for services rendered. Also, if the above is not true, I agree to pay in full for all services rendered, within 30 days from receiving a bill from Dr. Richard C. Downing.

I understand that if my insurance company changes and I fail to notify Dr. Richard Downing, I am responsible in full for all services rendered.

Signature of Member/Patient	Date Signed	Witness
_____	_____	_____
_____	_____	_____