INSURANCE VERIFICATION

Todays Date __________ Patient Name ____________________________________ DOB ____________

Insurance Co __________________________________ Insurance Phone _______________________

Effective Date____________________Patient ID# ____________________________________

Group # ________________ Payor ID_________ Fee Schedule to Bill ___________________

Benefits covered IN NETWORK or OUT OF NETWORK Preauth Necessary: YES/NO

Yearly MAX $_________ DED $__________ YTD PAID OUT $___________ CALENDAR/CONTRACT

PREVENTATIVE: ______________% BASIC: _____________% MAJOR: ____________%

Basic Includes: PERIO ENDO ORAL ___________________________________

Implant Coverage: YES / NO D6010 _____D6057 _____D6058 _____D7953_____D4265____

Missing Tooth Clause: YES / NO __________ Waiting Period: YES / NO___________

Downgrades:_______________________ CROWN Freq:_______________

Frequencies on: Prophy ________ per ________ Exam ________ per ________

Bitewings ________ per ________ PA's ________ per ________

Pano ________ per ________ Last Pano: _______________________

Perio Maint ____

SRP ___________ per _________ Quads allowed per day ________ Last SRP History: ___________

Fluoride: _________ Age limit:____________ Sealants age limit: _________ MOLARS ONLY?________

Night Guard / Occlusal Guard: D9944 ______________________ Arestin: D4381 ___________________

Ortho Coverage: YES / NO D8090:________ %: _________ MAX: _____________ YEAR LIFETIME

DED: _________ Age Limit: ___________ Waiting Period: _______________Initial Payment: $__________

Payment Auto/ manual Y / M / Q Allowable for Adult: _______Child: ______Retainers:______

Claim Address : Electronic claims w/ attachments