

INSURANCE VERIFICATION FORM

DATE Verified _____ Insurance Rep.'s Name _____

Patient Name: _____ Patient: Sp and or Child

Eligible _____

Name of Insured: _____ Insured SSN: _____

Employer: _____ Effect benefit year ____/____/____ D.O.B ____/____/____

Deductible: Individual _____ Family _____ Maximum _____ Remaining Benefits _____

Dental Percentages

Preventive: _____ % Basic _____ % Major _____ %

Endo _____ % Perio _____ % Oral Surgery _____ %

Frequencies

BWX 1 in 12 months _____ 2 in calendar year _____ Date of last set of BWXs (if any) _____

FMX/PAN: _____ per every _____ mo(s)/yr(s) Date of last FMX/PAN History (if any) _____

Prophy/Exam 2 per year _____ Every 6 months _____ To Date _____ To Month _____

Fluoride: Yes _____ No _____ One per every _____ Age Limit _____ and under. No Age limit _____

Sealants Yes _____ No _____ Molars only _____ Age Limit _____ 1 per tooth every _____ months/years

Other Benefit Information

Waiting Period for Major Treatment Yes _____ No _____ How Long _____

Missing tooth clause: Yes _____ No _____ How Long? _____

Replacements:

Single Crowns _____ years/months Bridge _____ years/months Partial/Dentures _____ years/months

Is pretreatment required? Yes _____ (if yes, amount \$ _____) No _____ but suggested at \$ _____

Orthodontics: Yes _____ No _____ Ded. _____ At _____ % Max _____ Age Limit _____

TMJ Yes _____ No _____ Benefit Medical Yes _____ Dental Yes _____

TMJ Appliance covered Yes _____ No _____

Appliances covered Yes _____ No _____ Bruxism Yes _____ No _____ At _____ %

Coordination of Benefits/Non-duplicating clause? Yes _____ No _____

Is this coverage Traditional _____ PPO _____ Fee Schedule _____

Group NO. _____ Payor ID No. _____

Phone Number: _____

Insurance Co.: _____

Claim Address: _____