

INSURANCE VERIFICATION

Date _____ Verified By _____ For _____

Family Coverage Y/N (Std COB _____ /Non-Dup. Clause _____ /Maint of Benefit _____)

Member Info.

Policy effect. Date _____

Member _____ DOB _____

SS# _____ Ins. Co. _____

Ins. Phone # _____ Payer ID# _____

Grp.# _____ Employer _____

Yearly Max\$ _____ Calendar Year or (Benefit Year ____ to ____)

Student Info Required? _____ Up to Date? _____

Ded.\$ _____ (met Y/N) Family Ded. Y/N \$ _____ Ded. waived on Prev. Y/N

PPO Plan? Y/N Are we in Network? Y/N Out of Network Benefits? Y/N

Insurance Co's Address:

Preventative _____ %

Prophy ___X___ Exams ___X___ BW ___X___ FMX ___X___

Sealants max age _____ Molars/Bi's limit ___X___ _____ %

Fluoride max age _____ Limit ___X___

Can we take BW's the same day we do a Pano/FMX? Y/N

Basic _____ %

Posterior composites- Reduced to Amalgam or paid UCR

Perio _____ % Oral Surg. _____ % Endo _____ %

4355 Full Mouth Deb. Covered Y/N _____ %

Prophy 30days later covered? Y/N at _____ %

4910 Perio. Maint. Freq. _____ % ___X___ E/O Prophy Y/N

4341 Root Planing/Curretage/Quadrant _____ % ___x___ /quad

4381 Arestin Covered Y/N? _____ % Freq: _____

Can we do 4342 Localized RPC same day as 1110 Prophy? Y/N

9940 Occlusal guard covered? Yes _____ No _____ for TMJ ? or Bruxism? _____ %

Major _____ %

Crowns B/M Replacement yr. Crowns _____ Bridges _____

Missing tooth clause Y/N _____ Waiting periods Y/N _____

02950 Crown B/U B/M Endo Req'd Y/N Pay on PREP or SEAT date Implants _____

Patient _____ Ben Used _____ BW _____ FMX/Pano _____

Patient _____ Ben Used _____ BW _____ FMX/Pano _____

Patient _____ Ben Used _____ BW _____ FMX/Pano _____

Patient _____ Ben Used _____ BW _____ FMX/Pano _____

Ortho\$ _____ Max _____ % _____ Ded. _____ age

Pre-Auth Suggested or Required \$ _____