Insurance Verification Form (*Ver. 7 - 10/15/10*)

Today's Date: _____ **Employee initials:** _____

Appointment Date: _____ **Spoke with:** _____

Subscriber Name:_____ **Subscriber DOB:**_____

SSN / ID #:_____ **Employer:**_____ **Group #:**_____

Policy #: _____ **Phone #:**_____ **Ins Request #** _____ **Coverage #** _____

Pt. Name:_____ **Patient DOB:** _____ **Pt Relationship to Subscriber**_____

Coverage Information

When Benefits Exceeded: □ **Use Full Fee** □ **Use Contract Fee**

Coverage: □ **Individual** □ **Family** □ **Employee + Spouse** □ **Employee + Dependent**

Coverage type: □ **DENTAL** □ **MEDICAL** □ **Medical Form** □ **Dental Form**

Insurance Company Full Name: _____

Claim Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone # _____ **Fax #** _____ **EDI Payer #** _____

Effective Date: _____ **Benefit Year Starts:** _____ **What network/Contract/Fee Schedule applies:** _____

Coverage Type: _____ ***PPO*** *(Participating)* ***MC*** *(Participating – Roster Based)* ***FFS*** *(Non-Particip. & Indemnity)*

Claim Time Limit: _____*days* **Coverage Age Limits:** Child_____ Student (College) Child_____ **Min Pre Auth Amount** _____

Coordination of Benefits Method: □ DOB rule □ Gender rule □ Coverage Length rule □ None □ Non Duplication Clause

Accept Assignment of Benefits: □ Yes □ No *(If **NO** we cannot schedule unless patient pays in full)* **Accept Signature on File:** □ Yes □ No

Yearly Maximum(s): $_____ □ All Services □ Other: _____ **Benefits for the year:** **USED** _____

Deductible Amount: **Individual:** _____ **Met?** □ Yes □ No **Family:** _____ **Met?** □ Yes □ No

Deductible Amount: □ **Lifetime** □ **Annual**

Deductible Applies to: □ All □ Preventive □ Basic □ Major □ Other (specify): _____

Per Visit Charge? *(normally for a managed care coverage)* **$**_____ □ None □ Additional □ Larger Once per day? □ Yes □ No

Patient pays lab? *(additional lab fee included on certain codes):* □ Yes □ No

Cover Previous Extractions? □ Yes (missing tooth clause **does not** apply) □ No (missing tooth clause applies)

Waiting Periods? Yes □ No □ Time:_____ Services_____

Preventive/Diagnostic Benefits:

Preventive: _____%

Diagnostic: _____%

Diagnostic FMX: _____%

Diagnostic BWX: _____%

Diagnostic PA: _____%

Sealants: _____% **Frequency:** _____

Space Maint: _____% **Frequency:** _____

Limited Eval: (0140) _____%

ViziLite: (0431) _____%

Basic Benefits:

Perio: Surg: ____% Non-Surg: _____%

FM Debridement: (4355) _____%

Arestin: (4381) □ Not Cov'd □ Cov'd _____%

Perio Maint: (4910) _____%

Oral Surgery: _____%

Simple Ext: (7111, 7140) _____%

Endo: _____%

Restorative: ____% **Frequency:** _____

SSC Primary: _____%

Major & Misc. Benefits:

Major: _____% **Crowns**:_____%

Build Ups, P&C: (2950,52,54) _____%

Implants: _____%

Prosthetics: _____%

Repairs: _____% Relines:_____%

Removable: _____% Fixed:_____%

Palliative:(9110) ____% **GA**: (9220/ 21) _____%

Nitrous(9230): _____% **IV**(9241):_____%

Bleaching: (9972,73,74) _____%

Veneers: □ Not Cov'd □ Cov'd _____%

Occ. Guards: □ Not Cov'd □ Cov'd _____%

Posterior Crowns: □ Alt. Benefit (Downgraded)? □ Yes □ No

Posterior Composites: □ Covered _____% □ Covered at Amalgam Rate (downgraded) □ Not Covered □ Pre Molars: _____ □ Molars: _____

□ Alternate Benefit? □ Yes □ No Tooth Number _____ **Consult: (9310)** _____%

Procedure Limitations

Exams: (0120) □ 1/6 months □ 2/year □ Other: _____ Date of last Exam: _____

FMX (0210) / **Pan** (0330) □ 1/36 months □ 1/60 months □ Other: _____ Date of last FMX: _____

Bitewings: (0272, 0274) □ 1/6 months □ 1/12 months □ 1/year □ 2/year □ Other: _____ Date of last BWX: _____

Prophy (1110, 1120) □ 1/6 months □ 2/year □ Age Limit (1120) _____ □ Other: _____ Date of last Prophy: _____

Fluoride (1203, 1204, 1206): □ Yes □ No Age limit: _____ Frequency: _____ **ViziLite**: (0431) Age _____ Frequency _____

Sealants: (1351) □ Yes □ No Age limit(s): _____ Teeth Covered: _____

Root Planing: (4341,4342) # Quads/Day: _____ every _____ month(s) _____ year(s)

Full Mouth Debrid: (4355) □ 1/6 months □ 1/12 months □ 1/year □ 2/year_____ Lifetime **Arestin** (4381):Frequency *(if covered):* _____

Perio Maint: (4910) □ Yes □ No □ 1/6 months □ 2/12 months □ 1/3 months □ 4/year □ Alt Benefit? Date of last Perio Maint: _____

Prosth (Removable): □ 5 years □ 10 years □ Other (specify): _____ Waiting Period? _____ Bill on Prep or Seat? _____

Prosth (Fixed/Crowns): □ 5 years □ 10 years □ Other (specify): _____ Waiting Period? _____ Bill on Prep or Seat? _____

Other Info to include: _____