INSURANCE VERIFICATION FOR ORAL SURGERY

Today's Date: _____ Time: _____ TC: _____ Date Verified: _____

Patient's Name: _____ DOB: _____ Relationship: _____ SS: _____

Member's Name: _____ DOB: _____Member ID#/SS: _____

Employer: _____Group #_____

Insurance Company Name:_____ Plan: _____

INSURANCE PAYOR NUMBER_____ ACCEPTS ATTACHMENTS? _____YES _____ NO

Claim Address: _____ City: _____ State: _____ Zip Code: _____

Telephone#: _____ Name of Insurance Person: _____

In Network Benefits? Yes _____ No _____ Out of Network Benefits? Yes _____ No _____

Benefit Coverage: Employee: _____ Employee and Spouse: _____ Family: _____ Other: _____

Effective Date: _____ Policy Still in Effect? Yes _____ No _____ Termed? _____ Calendar? Yes _____ No _____

DENTAL

Individual MAX $: _____ Individual Max $ Used: _____ Individual Max $ Left: _____

Individual DED $: _____ Individual Ded Met $: _____ Family Ded $: _____ Family Ded Met $: _____

Waiting Period? Yes _____ No _____ Has it Been Met? Yes _____ No _____

Preventative: _____% Basic: _____% Major: _____%

Date of Last: FMX: _____ Pano: _____ Exam; _____

Frequency: FMX/Pano: I in 3: _____ I in 5: _____ No history: _____

	9310	0140
Coverage		
Frequency		

Add'l Codes: Exclusions and Limitations

0322: CT Scan_____
6010: Implants _____
7280/7283 access unerupted/plcmnt of device; _____
9230: Nitrous Gas:_____
9241/9242: Conscious IV Sedation_____

Extractions & Impactions

7110		7111		7120	
7140		7210		7220	
7230		7240		7241	
7250					

IV SEDATION-IS IT SUBJECT TO REVIEW? Yes _____ No _____

9220 (Deep IV): _____

9221 (Deep IV): _____

PRE DETERMINATION REQUIRED? Yes _____ No _____ SUBJECT TO MEDICAL FIRST? Yes _____ No _____

Comments: _____

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