PERIODONTAL INSURANCE VERIFICATION FORM

Date: _____ Team Member: _____

Patient's Name: _____ Patient's DOB: _____

*Policyholder's Name: _____ SS#: _____

*Policyholder's Employer: _____ DOB: _____

*Insurance Company Name: _____ Ins. Phone # _____

Insurance Company Address:

_____

_____

Insurance Group Number: _____

Insurance Effective Date: _____ Spoke With: _____

Dental Yearly Maximum $_____ Dental Benefits Remaining $_____

Deductible $_____ Has Deductible Been Met? _____

Paid At _____% Age Limit: _____

Indemnity Pan: YES NO PPO: YES NO DMO: YES NO

Is There a Waiting Period? _____

Coordination of Benefits? _____

Perio Exam (Code D0180) Covered? _____ at _____%

FMX (Code D0210) Covered? _____ at _____%

Has an FMX been taken in the last 3 years? _____

Comments:

_____

_____

_____

_____