

INSURANCE VERIFICATION FORM

Patient Name _____ Social Security # _____ Birthday _____ Relation to Insured _____

Insured Name _____ Social Security # _____ Birthday _____ PPO/DMO _____

Employer Name _____ Telephone # _____ Contact Person _____ Address _____

Insurance Company _____ Telephone # _____ Contact Person _____ Address to Send Claims _____

Group Policy # _____ Effective Date _____ Dependent Coverage YES _____ NO _____

Yearly Maximum Paid by Insurance \$ _____ Amount Remaining This Year \$ _____

Deductible Met for Year? YES NO

<u>TREATMENT</u>	<u>DEDUCTIBLE</u>	<u>% INSURANCE COVERS</u>
Preventive	_____	_____
Basic	_____	_____
Major	_____	_____

CIRCLE ONE

Perlo - Basic _____ Major
 Endo - Basic _____ Major
 Oral - Basic _____ Major

FREQUENCY

Exams _____ Cleanings _____
 FMX _____ Bitewings _____
 Date of last FMX/Panorex _____

PLEASE CIRCLE ONE ANSWER PER QUESTION

Are the following treatments covered?

Sealants	Yes	No	If covered, to what age? _____
Fluoride	Yes	No	If covered, to what age? _____
Debridement	Yes	No	
Perlo Maintenance	Yes	No	
Composites	Yes	No	(Posterior)

Does insurance company accept assignment? Yes No

Is Pre-determination required? Yes No

Is there a missing tooth clause? Yes No

New Patients Only

Appointment Date _____

ANY OTHER EXCLUSIONS _____

Prior date of Prosthesis Placement _____/History _____

Replacement Period Dentures/Partials 3 Yrs 5 Yrs

Is there a waiting period for new enrollees? Yes No

Date Verified _____

Frequency allowed for Reline/Rebase 3 Yrs 5 Yrs

Verified By _____

Are Precision Attachments Covered? Yes No

Insurance Rep _____