

# INSURANCE VERIFICATION

Date \_\_\_\_\_ Verified By \_\_\_\_\_ For \_\_\_\_\_  
Family Coverage Y/N (Stnd 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 company'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 \$ \_\_\_\_\_

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