Dental Insurance Verification **Today's Date: _____** **Employee Initials: _____**

Appointment Date: _____ **Insurance Rep Name: _____**

Patient Name: _____ Birthdate: _____

Subscriber Name: _____ Birthdate: _____

Relationship: _____ Employer Name: _____

Insurance Company _____ Phone #_____

Member ID or SS# _____ Group #_____

Claims Address: _____

_____ Payor ID: _____

Effective Date: _____ Calendar Year or Fiscal Year Rollover – Y or N _____

Annual Maximum: _____ Used: _____ Annual Deductible:_____ Met:____

Deductible Applies to: Preventive Basic & Major All

Separate Maximum for Preventive: Yes No

Preventive: _____ % Basic: _____% Major: _____%

Perio: _____% Endo _____% Oral Surgery _____%

Post & Core (D2954) _____% FMD (D4355) _____% Buildup (D2950)_____%

Implants _____% Nightguards _____%

FREQUENCY LIMITATIONS:

Comp Exam (D0150) _____ Limited Exam (D0140) _____ Periodic Exam (D0120)_____

Perio Eval (D0180) _____ Bwx(D0274)_____ FMX/PANO (D0210/D0330)_____

Arestin (D4381)_____ Perio Maintenance (D4910)_____ Prophy_____

Sealants _____Fluoride _____ Nightguards_____

Composites: _____ Are composites downgraded YES NO

Implants _____ Scaling & Root Planing _____ 2 quads or 4 quads

Waiting Period for Major? YES NO Crowns/Bridges/Major paid on Prep or Seat

Missing Tooth Clause Yes No Coordination of Benefits ?_____

Other Notes: _____

Additional Notes: